

**Indian Health Service  
Facilities Needs Assessment and  
Prioritization Criteria Workgroup**

**Report on Findings  
and Recommendations**

*NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS*

This report reflects the activities and recommendations of the IHS Facility Needs Assessment and Priority Criteria Workgroup. It was prepared under contract with the Indian Health Service for the IHS and the Facility Appropriation Advisory Board.

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## **EXECUTIVE SUMMARY**

The Indian Health Service (IHS) Facility Needs Assessment and Priority Criteria Workgroup was first convened in February, 2001 for the purpose of developing and implementing a one-year work schedule to develop specific recommendations regarding changes to the IHS system. The Workgroup was composed of tribal leaders, health directors, planners, urban health directors and regional tribal associations. IHS staff provided technical support. The Workgroup met five (5) times over the course of the next 12 months to develop specific recommendations. The IHS Director and the IHS Facility Appropriation Advisory Board (FAAB) requested that the Workgroup develop recommendations regarding:

- The criteria to be used for establishing and annually reviewing the need for facilities construction in Indian Country.
- The criteria and relative weight of each criterion to be used to prioritize among competing projects.
- Strategies for dealing with (coordinating and integrating) the prioritization needs of the various health care facilities construction programs (inpatient facilities; outpatient facilities; dental units program; Joint Venture Program; Small Ambulatory Program; the proposed Loan Guarantee Program; etc.).

The following is a executive summary of their recommendations.

### ***A. Needs Assessment Recommendations***

Many of the recommendations proposed by the Workgroup regarding Needs Assessments are based upon the assumption that the Health System Planing (HSP) Process software can be easily applied in a fair, consistent manner across all 12 Areas.

#### **1. Health System Planning**

**ISSUE:** There is currently no routinely administered system for assessing the facility needs in the Indian health delivery system serving IHS, tribal and urban (I/T/U) programs. Without a consistent method of assessing need, it is difficult if not impossible to define the real need in terms that are reliable and credible. The IHS invested in the development of a software system designed to identify service and facility needs for defined populations. The system has been implemented in only a few areas, but has proven to be a useful and effective tool. The system is not driven by workload data. It factors in local available alternative resources and applies generally accepted utilization rates for service types to best describe needed services and facilities for a population. This latest technology is available to Indian health systems, but should be uniformly applied in order produce a national picture of need.

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**RECOMMENDATION:** We recommend that the IHS in consultation with the I/T/U's implement the "Health System Planning" (HSP) software/model be applied locally to determine the services and facilities required in individual service areas nation-wide. Based upon these community-specific or service area specific HSP analyses, a community specific Master Plan will be generated to quantify the costs associated with the construction of expanded, replaced or new facilities.

### **2. Area Master Plans:**

**ISSUE:** Assuming that each community will engage in the HSP method of establishing a definition of services and facilities needs, these data can then be integrated at the Area level to produce a Master Plan. The importance of integrating these data must be emphasized. A Master Plan will better develop the HSP to show multi-tribal systems, regional levels of care and referral systems. It will also help to establish relative priority within an Area for construction and development of new services. It will prevent IHS construction funds from supporting the spontaneous construction of facilities that are not rational or warranted within the context of the Area-wide service delivery system.

**RECOMMENDATION:** We recommend that the results of the community-specific HSP services and facilities analyses be integrated into a regional Area-wide Master Plan for each of the 12 IHS Areas, in consultation with I/T/U's, which will describe the services and facilities for the Area, the required expanded, replacement or new construction for needed facilities and estimated costs associated with those projects, roughly estimated based on facility type and size.

### **3. HSP Adaptability for Smaller Communities:**

**ISSUE:** Currently the HSP makes certain planning assumptions about each community it examines. For example, the HSP may not be formulated to accurately examine the services and facility needs for populations of 100 to 500 residents. American Indian and Alaska Native communities in these rural, remote settings are not served well under the existing IHS system for establishing priority for construction funding. While the HSP is, in the view of the Workgroup, ready to be applied to rational service delivery areas and/or smaller communities, it may need to be adapted to ensure it truly reflects the needs of rural, remote communities. However, the Workgroup felt that making these adaptations for communities of less than 100 users may not be productive in light of the overall demand for services and facilities nation-wide.

**RECOMMENDATION:** We recommend the IHS invest in making the necessary modifications to the current HSP technology, so that communities of not less than 100 users can be included in the updated HSP analysis.

### **4. Space Deficiency for Core Services Only:**

**ISSUE:** Currently the HSP model examines core services that are traditionally included in basic health care delivery systems, i.e., outpatient medical care, outpatient dental

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care, laboratory services, pharmacy services, mental health counseling, inpatient services, etc. The HSP model does not include templates to calculate needed services and facilities for other alternative aspects of health delivery, ie, wellness centers, long term care, traditional Native healing. While the Workgroup is supportive of the IHS eventually making these alternative services a part of the HSP, the Workgroup recognizes that without agreed upon “standards” for these new services, communities could potentially skew the results of the HSP by loading in extra square footage for alternative or “off-template” services. This would unfairly elevate the relative need of one community over another based upon the inclusion of these off-template services. It is important that this system compare “apples to apples” and “oranges to oranges”. Therefore, until such time as adequate tribal consultation has occurred to reach national consensus on standards for off-template services, only those existing core services within the HSP should be applied for establishing a national Needs Assessment and Priority Criteria system.

**RECOMMENDATION:** We recommend that calculations for space deficiency which results from application of the HSP will be based only upon those “core health services” currently within the template formula of the HSP. We caution the expansion of these templates until there is consultation and agreement regarding space requirement standards for off-template services.

### **5. Off-Template Services and Future Planning:**

**ISSUE:** Services considered to be “off-template” within the HSP system are still important to the long term health and wellness of AI/AN populations. For example, as the AI/AN population ages, long term care services will become more and more important. It is important that off-template services be defined and standards developed through a rational consultation process that weighs I/T/U input, demographic data and is supported or verified through industry standards if such exist. Without close care and protection for the integrity and reliability of off-template standards, the Workgroup fears that the results of a national Needs Assessment will become suspect and therefore discounted by Congressional decision-makers.

**RECOMMENDATION:** We recommend that the IHS invest in a long term plan to develop formula for templates for alternative services not currently described in the HSP to be applied in the future. These alternative services could include, but not be limited to, wellness centers, long term care facilities, traditional medicine, alcohol and substance abuse treatment, preventive services, etc.

### **6. Unit Price Budgeting:**

**ISSUE:** There are a variety of ways for calculating the total estimated costs for needed facilities. It will be important for the integrity and reliability of the national Needs Assessment that some method for standardized unit costs that are regionally sensitive be utilized. Using a regionally sensitive standard unit cost will enable quick calculations of construction projects based upon the level of facility space identified through the

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HSP. Again, the Workgroup is concerned that a national Needs Assessment should reflect some level of comparable standards applied to health services and facilities needs across Indian Country.

**RECOMMENDATION:** In accordance with acceptable IHS Standards, we recommend that regionally appropriate unit price budget calculations be utilized within each of the Local and Area Master Plans to calculate preliminary estimated costs associated with construction projects.

### **7. Repair vs. Replacement:**

**ISSUE:** As a part of the national Needs Assessment it will be important to identify not just new and replacement construction needs, but also repair or renovation needs as well. A means for determining when a project warrants repair and when a project warrants replacement is necessary. Such a mechanism should be applied across the board in a standard formula.

**RECOMMENDATION:** We recommend that industry standards be followed for determining repair or replacement options, such that if repair estimates exceed 75% of replacement estimates, projects may be recommended for replacement.

### **8. Non-IHS Funding:**

**ISSUE:** This Workgroup found that non-IHS dollars far outpace the investment of IHS dollars in the construction of health care facilities in I/T/U settings across the country. Investment of non-IHS resources should be encouraged and leveraged to provide expanded resources and facilities. It is important to understand the significance of these alternate resources and track these investments over time.

**RECOMMENDATION:** We recommend that each Area Master Plan include a thorough description of the space and dollars for new or replacement construction of tribal and urban health facilities constructed with non-IHS dollars, from 1996 to present.

## ***B. Rating Criteria Recommendations***

**ISSUE:** One of the most important aspects of conducting the Needs Assessment utilizing the HSP model, is to produce comparable data so that proposals can be compared to one another in a fair manner. Assuming the HSP will produce data that can fairly be compared from project to project, the Workgroup developed the following specific recommendations for conducting both Area and National priority ranking. The Workgroup understands that the IHS may need to respond to Congress soon regarding new construction projects on the priority list. The following recommendations should be taken into consideration before any future priority ranking occurs. Also, because only IHS and tribal projects are considered under the current construction priority system, some method for ranking urban Indian projects separately for consideration of funding under the Urban Indian health authority has also been considered.

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### **RECOMMENDATIONS:**

- We recommend that the IHS NOT apply the existing HFCPS to add facilities to the priority lists. Rather, we recommend a new system be implemented for any future priority ranking based upon the specific proposals and recommendations contained in this report.
- The Workgroup decided that competing facilities should be ranked according to the following two categories: (1) Urban Indian facilities will be ranked with other Urban Indian facilities when requesting consideration for Title V funding; and (2) Tribal and I.H.S. facilities will be ranked against each other when requesting consideration for funding under the construction line-item of the I.H.S. budget.
- Proposed Priority Criteria and Criteria Weighting:

**1. Master Plan Required:** To be considered for the priority list, a project must be included in its respective Area Master Plan.

**2. Relative Criterion Weights:** The Workgroup recommends that the following criteria be used with the corresponding relative weights shown:

<u>Criteria</u>	<u>Proposed Weighting:</u>
a. Facility Deficiency Scores	35
b. Isolation	10
c. Documented Barriers	10
d. Health Indicators	15
e. Innovation	15
f. Type of Facility	<u>15</u>
Total Possible	100

### **3. Justification and Explanation of Proposed Criteria:**

- Facility Deficiency Scores:** These scores weigh the greatest in the proposed criteria. The score reflects the gap between existing space and required space as determined through the HSP analysis. Factors such as facility age, condition of facility, and user population are included in this analysis.
- Isolation:** This criterion refers to the physical distance of the population to the nearest health center or hospital. To receive full weight for this criterion a community would need to be 60 miles or more from the nearest hospital and 30 miles to the nearest outpatient facility, or removed from that facility by air travel or water. The closer the alternative facilities, the less weight assigned.
- Documented Barriers:** This criterion could be calculated in a number of ways, and is included to cover “access barriers other than geographic distance”, such as economic barriers, cultural barriers, transportation barriers, racial

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- discrimination other socio-economic factors. Developing objective measures that can be documented and consistently applied will be a challenge.
- d. **Health Status Indicators:** Health status indicators represent a new and important addition to facility construction ranking criteria. This criterion can also be calculated in a number of ways. For purposes of discussion, we have presented two options, one looking at infant mortality rates as a ratio to national U.S. rates, and “Years of Productive Lives Lost” (YPLL) as a ration to U.S. rates. There may be other, more appropriate measures, such as those under development at Johns Hopkins University which will incorporate a range of both morbidity and mortality data.
  - e. **Innovation:** Significant weight is assigned to this “new” criterion proposed by the Workgroup. Additional work is needed to define the types of innovations which might qualify for added weight. For discussion purposes, we have provided examples of innovative steps which could provide incremental points in this area. This could include investments of non-IHS dollars in the project, collaboration with other tribes or consortia, or regional partnerships.
  - f. **Type of Facility:** These factors will be consistent with the standards for services and facilities reflected in the HSP. The Workgroup wanted to provide a mechanism to prioritize smaller outpatient facilities over inpatient facilities and support community-based prevention and primary care. This criterion would be applied based upon a grid that assigned values inversely to projects based upon size. The larger the project the lower the value. The smaller the project the greater the value.
    - Defining Thresholds and Values for Facility Types
      - i) Medical Center or regional inpatient facilities
      - ii) Small Hospital and other local inpatient facilities
      - iii) Primary Care Health Center and other comprehensive outpatient settings;
      - iv) Health Station and other solo practitioner stations

### ***C. Integrated System Recommendations***

These recommendations are based upon an assumption that Congress will provide recurring construction appropriations, which can be allocated consistent with the proposed recommendations below.

#### **1. Universal Priority List:**

**ISSUE:** Rather than develop multiple lists for different types of facilities, ie outpatient list, inpatient list, etc., the Workgroup proposes that a universal priority list be developed. Only through a universal priority list can priority ranking occur which shows priority of outpatient services over inpatient services for example. While Congress may exercise its option to pull from the list those inpatient facilities in a ranked order, it is important to have a universal list that reflects the priorities across Indian Country.

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**RECOMMENDATION:** The Workgroup recommends that priority ranking be conducted for all of the many construction programs proposed in each of the 12 Area Master Plans of the IHS, not just the 10 top outpatient and 10 top inpatient facilities. From this ranking a universal national priority list will be produced that includes all projects in the Area Master Plans, including inpatient, outpatient, dental, joint venture, small ambulatory clinics, staff quarters, regional youth treatment centers and other proposals in the Master Plan. New services that are currently outside the existing HSP template, such as long term care, wellness centers, etc., will be added to this priority list as developed and accepted under an amended national HSP format.

### **2. National Priority List for Congressional Consideration:**

**ISSUE:** The Workgroup proposes that there be two levels of review and allocation of resources for construction projects. Those projects which include increases in recurring costs (such as increased staffing and increased operation/maintenance) should fall under the review and approval of the U.S. Congress for construction appropriations. Other “one-time” construction projects that do not include increases in recurring costs for the IHS budget should be handled separately, through Area allocations.

**RECOMMENDATION:** From the Universal List, all projects which have implications for recurring costs (staffing, operations) will be compiled in a National Priority List for consideration for Congressional appropriations. This may include inpatient facilities, outpatient facilities, staff quarters, joint venture projects, etc.

### **3. Area Priority List:**

**ISSUE:** The Workgroup is proposing a greater role and involvement of I/T/U’s through the Area Offices of the IHS to better plan and implement their Master Plan’s through the allocation of construction funds for one-time projects that do not include increases in recurring costs.

**RECOMMENDATION:** All construction projects that do not involve new or expanded staffing or increased recurring commitments from the IHS, will be deferred to the Area Priority List in each of the 12 IHS Areas. These may include regional youth treatment centers, dental clinics, small ambulatory care clinics, or other innovative or alternatively funded projects. Area ranking of these projects will be conducted based upon the proposed criteria.

### **4. Area Percentage Allocation:**

**ISSUE:** The Workgroup is proposing that each of the 12 IHS Areas receive an allocation of the annual construction appropriations for purposes of making allocations to one-time projects that are included in the Area Master Plans. This method for allocating resources to the Areas will expand the importance of the Area Master Plan and the rational allocation of construction dollars for priority projects. The Workgroup expects

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that such a system will enhance Area planning and regional health delivery coordination.

**RECOMMENDATION:** We recommend that a percentage of annual construction appropriations be allocated to each of the 12 Areas according to a need-based formula. Each Area will determine for themselves how best to allocate these Area construction dollars according to the Area Master Plan and Area Priority Lists, including but not limited to, construction costs, debt relief, loan guarantees and other innovative construction strategies.

### **5. Amendments to Authorizing Statutes:**

**ISSUE:** Existing provisions in the Indian Health Care Improvement Act currently prevent the application of many of our recommendations. For example, the small ambulatory clinic program is restricted to only communities with 2,000 or more population. This definition of a “small clinic”, is too restrictive and eliminates many truly small American Indian and Alaska Native communities from being eligible for funding. Existing law that requires the IHS to provide the 10-top outpatient and 10-top inpatient facilities on the construction priority list, is not consistent with the Workgroup proposals that all facilities be rated and presented in total.

**RECOMMENDATION:** We recommend that IHS seek Congressional amendments to authorizing statutes to eliminate threshold restrictions on categorically authorized and funded facility construction programs, such as small ambulatory clinic restrictions to communities with 2,000 users or more, to be consistent with existing HSP formula and proposed integration recommendations.

## **DAVIS/BACON WAIVERS**

**ISSUE:** A major drain on limited construction dollars for new and replacement health facilities in AI/AN communities is the federal requirement that the Davis/Bacon Act govern IHS funded construction. In many rural, remote areas where IHS construction dollars are used to build health facilities, the Davis/Bacon requirement means that construction costs are drastically inflated and construction funding is provided to contractors from outside AI/AN communities. Rather, the Workgroup proposes that these requirements be waived for IHS funded construction so that construction revenues can stay within AI/AN communities and costs can be reduced.

**RECOMMENDATION:** The Workgroup is recommending that Congress provide a waiver of the Davis Bacon Act for all construction funded through the IHS appropriations. This waiver can be achieved through either authorizing statute or through annual stipulations on the Interior Appropriation Acts.

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The following table provides a quick comparison of Workgroup recommendations with the current Health Facility Construction Priority System used by IHS.

**COMPARISON OF HEALTH FACILITIES PRIORITY SYSTEMS**

<b>Criteria</b>	<b>Existing-IHS-HFCPS</b>	<b>Workgroup Recommendations/Weight</b>
<b>FACILITY DEFICIENCY</b>	Space required for workload is adjusted for existing space and condition.	Use HSP space minus existing space adjusted for condition (BEMAR). (35%)
<ul style="list-style-type: none"> <li>• Facility Age</li> </ul>	Age is included in Facility space adjustment	Separately age adjusted
<ul style="list-style-type: none"> <li>• Population and Demographics</li> </ul>	User population only included in Facility Deficiency	Census (service population) and demographics included in HSP space calculations
<b>ISOLATION</b>	Factor applied by formula for distance to IP, OP and Alternate Facility	Factor applied for distance to nearest health care facility. (10%)
<b>ACCESS BARRIERS (other than isolation)</b>	NONE	Factors are added for access barriers, such as language, culture, economics, discrimination etc. (10%)
<b>HEALTH INDICATORS</b>	NONE	Factors for Infant Mortality Rates, morbidity rates or Hopkins ACGs are being considered. (15%)
<b>INNOVATION</b>	NONE	Factors such as use of Non-IHS dollars, collaboration with other Tribes, new health programs or regional partnerships would score higher for this criteria. (15%)
<b>FACILITY TYPE</b>	NONE	Smaller facilities would score higher for this criteria. (15%)

## **I. INTRODUCTION**

### **A. Report Overview**

This is a Final Report of Recommendations submitted by the Indian Health Service Facilities Needs Assessment and Priority Criteria Workgroup to the Indian Health Service Director and his Facility Appropriations Advisory Board (FAAB).

At the request of the F.A.A.B, the Director of the Indian Health Service (I.H.S.) established the Facilities Needs Assessment and Priority Criteria Workgroup to develop recommendations to the Indian Health Service relating to the following areas:

- The criteria to be used for establishing and annually reviewing the need for facilities construction in Indian Country.
- The criteria and relative weight of each criterion to be used to prioritize among competing projects.
- Strategies for dealing with (coordinating and integrating) the prioritization needs of the various health care facilities construction programs (inpatient facilities; outpatient facilities; dental units program; Joint Venture Program; Small Ambulatory Program; the proposed Loan Guarantee Program; etc.).

Additionally, the Workgroup was asked to address specific issues raised in the United States Congress in its Conference Report accompanying the Fiscal Year 2000 Interior Appropriations Act, which included the following questions:

- *How should the prioritization process address projects funded primarily by tribes?*
- *How should anomalies such as extremely remote locations be addressed in the prioritization process?*
- *How should projects that involve no or minimal operational cost increases be incorporated in the prioritization process?*
- *How should alternative financing and modular construction options be addressed in the prioritization process?*
- *What can be done to make the current system for construction of facilities a more flexible and responsive program?*

This effort was also undertaken with the knowledge that far reaching amendments to the Indian Health Care Improvement Act have been proposed by tribes and urban programs, which would substantially expand the ways in which health facility construction is accomplished through the IHS.

This report represents the considerations, findings and recommendations of the Facility Needs Assessment and Priority Criteria Workgroup regarding how the IHS can best

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amend and revise its current facility construction system. We have discovered that no formula is without flaws, and competitive ranking among worthy construction projects suggests some much needed facilities may not be constructed. This Workgroup has attempted to provide recommendations which will fairly present ALL community health facility construction proposals regardless of size or location. However, we found that ranking proposals for consideration for Congressional appropriations requires the application of criteria that will best serve the most patients served within the I/T/U system, while perhaps not meeting all needs.

### **B. Background**

The United States maintains a unique moral and legal obligation to provide health services to American Indians and Alaska Natives. This obligation is based upon the U.S. Constitution, numerous Indian treaties, federal laws, Supreme Court rulings and Executive Orders. The federal government carries out this responsibility primarily through the Indian Health Service (IHS), an agency within the Department of Health and Human Services (DHHS).

The IHS, provides preventive, curative, and environmental health services to over 1.4 million eligible Indian beneficiaries across the United States. A large part of these activities are housed within inpatient and outpatient facilities and staff quarters built by the federal government specifically for this purpose. In addition to federally constructed facilities, Indian tribes and urban Indian health providers have secured alternative funding, to construct new or replacement health care facilities.

The IHS operates through 12 administrative "Areas" and within each IHS Area are numerous service units. Nationally there are 150 service units with 84 operated by tribes under the Indian Self-Determination and Education Assistance Act. Indian health services are provided through three different mechanisms: (1) The IHS provides services directly through federal facilities and staffing or through purchase of services from outside private vendors; (2) American Indian and Alaska Native (AI/AN) tribes provide services under contract with the IHS through the authority of the Indian Self-Determination Act; and (3) IHS contracts with 34 Urban Indian health programs, under Title V of the Indian Health Care Improvement Act, to assist AI/AN people living in cities across the United States. Together, the IHS, tribal and urban (I/T/U) providers compose the direct delivery components of the overall Indian health system.

The authority for the Indian Health Service to construct health care facilities for tribes rests primarily in the Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976. Under these two authorities the IHS has implemented a facility construction priority system, whereby individual projects are assessed and prioritized for potential Congressional funding for planning, construction and operation.

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In 1955, the responsibility to provide health services was transferred out of the Department of Interior and into the Department of Health, Education and Welfare, via the Transfer Act of 1955 (42 U.S.C. 2001 et. seq.). Later, the IHS was provided authority to contribute toward the construction of community hospitals when it was clear that Indian patients would benefit from the facility, under the Indian Health Facilities Act of 1957 (42 U.S.C. 2005). This little known authority has had only a minimal impact on the need for new health care facilities in Indian country. In 1959, the Indian Sanitation Facilities and Services Act (42 U.S.C. 2004) substantially expanded the role of IHS to ensure safe public health environments for Indian communities, including safe drinking water, drainage facilities, sanitary waste and sewer systems. In 1976, the Indian Health Care Improvement Act (25 U.S.C. 1601 et. seq.) was enacted, which vastly expanded and more clearly defined the roles and responsibilities of the Indian Health Services with regard to facility replacement and construction.

### ***1. Legislative Authority***

The U.S. Congress first extended legislative authority to the federal government to provide health services to American Indians and Alaska Natives through the 1921 Snyder Act, which stated:

*“Be it enacted . . . That the Bureau of Indian Affairs, under the supervision of the Secretary of Interior, shall direct supervise, and expend such moneys as Congress may from time to time appropriate for the benefit, care, and assistance of the Indians throughout the United States for the following purposes, . . . For relief of distress and conservation of health... for the employment of ... physicians... and other employees.”*

The enactment of the Indian Health Care Improvement Act of 1976 provided broad authority to the Indian Health Service and detailed guidance to address longstanding deficiencies in health care services and facilities for Indian communities. Title III of the Act specifically addressed facility needs. Later amendments to the Act included additional facility provisions in Titles VII and VIII and more thoroughly summarizes the many responsibilities of the federal government regarding health facilities in Indian Country.

- **Consultation, Closures of Facilities and Reports (Section 301):** Inpatient facilities programs for new construction, modernization, and/or major renovation of inpatient facilities is provided. The IHS provides Congress with an annual 10 top-priority projects for inpatient facilities. An Outpatient Facilities program is also provided, which covers new construction, modernization, and/or major renovation of outpatient facilities. This also includes the 10 top-priority listing for outpatient projects. Construction for staff quarters in remote service delivery areas is also covered under this section. Consultation with tribes regarding planned closures of any facilities is also required under this section.
- **Safe Water and Sanitary Waste Disposal (Section 302):** This section provides authority for the IHS to provide technical assistance to tribes, and for the Department

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of Housing and Urban Development to transfer funds to the IHS for purposes of safe water and sanitary waste disposal.

- **Preference to Indians and Indian Firms (Section 303):** This section provides the IHS authority to give preference to Indian owned businesses for construction and renovation projects.
- **Soboba Sanitation Facilities (Section 304):** Soboba Sanitation Facilities section provides specific authority for the Soboba Indian community to receive all services authorized.
- **Expenditure of Non-Service Funds for Renovation (Section 305):** This section authorizes the IHS to provide additional staff and equipment as needed, when a tribe renovates an existing IHS facility using non-IHS funds.
- **Grant Program for the Construction, Expansion, and Modernization of Small Ambulatory Care Facilities (Section 306):** The Small Ambulatory Health Center Grants program is authorized to provide grants to tribes that present acceptable proposals for construction, expansion or modernization of tribally-operated (non-IHS) facilities. It is provided to assist tribes construct non-federal, tribal clinics that are not on the priority list.
- **Indian Health Care Delivery Demonstration Project (Section 307):** The Indian Health Care Delivery Demonstration Program provided contracts or grants to tribes that develop innovative plans for demonstration projects for alternative means of providing health care services. Specific waivers are provided to allow for creative ventures. Specific sites were identified by name. These sites had originally been targeted for closure.
- **Land Transfer (Section 308):** Land Transfer authority is provided for the Chemawa Indian School in Oregon to develop health services.
- **Authorization of Appropriations (Section 309):** This section provides Congress with the authority to make annual appropriations for IHS facility purposes.
- **Applicability of Buy American Requirement (Section 310):** This provision extends the requirements of the Buy American Act to procurements made by or through the IHS under provisions of this Title.
- **Indian Youth Service Program (Section 704):** A limited number of Youth Regional Treatment Centers were authorized to be constructed in each Area of the IHS to provide residential (inpatient) alcohol and substance abuse treatment for Indian youth. Construction and renovation funding was also authorized and monitored through the IHS for each of the sites.
- **Demonstration Project for Tribal Management of Health Care Services (Section 818):** Joint Venture Demonstration projects are authorized to allow the IHS to work with tribes in the development of new or replacement facilities, paid for by the tribe and provided to the IHS on a no-cost lease. In exchange, the IHS is required to provide appropriate equipment, staffing and maintain the facility.

## ***2. Current Health Facility Construction Priority System***

The current Health Care Facilities Construction Inventory & Priority System (HFCPS) is a means to review competing proposals for health facility construction and is composed of three (3) phases. These phases permit the IHS to review, evaluate and rank various

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proposals for construction of inpatient and outpatient facilities. To even be considered for the HFCPS priority system inpatient facilities must provide no less than 5,500 inpatient days annually (or an average daily patient load of 15 patients); and outpatient facilities must provide more than 4,400 outpatient visits annually. The three phases of the HFCPS provide for increasingly more rigorous and competitive levels of review, weeding-out projects and advancing more competitive proposals to the next level:

- Phase I: Uses current statistical data; Distance to nearest facility; and Age of largest component;
- Phase II: Projected data (10 years); Average distance to facilities that can handle workload and average age from the Real Property Inventory;
- Phase III: Development of a formal "Program Justification Document" (PJD) , which is a planning document describing the action to be taken, usually construction, to meet program needs.

During Phases I and II, weighted criteria are applied to the proposals in an effort to rank competing requests so that only the highest ranking projects advance to the next level. Three major factors are "multiplied together" in order to determine the ranking of proposed projects. These three ranking factors are:

The Relative Need Factor: Relative need is a function of the ratio of the required space to the (adjusted) existing space, if any. This factor is the most significant in the evaluation formula and has a value between 1 and 4.

The Absolute Need Factor: Absolute need is a function of the required space minus the (adjusted) existing space, if any. This factor has a value between 0 and 1.5 in the evaluation formula.

The Isolation/Alternatives Factor: The isolation of a location and/or the availability of alternative health care services are determined by the distance to these alternative resources. In the evaluation formula, this factor has a ratio of 1:1.6 for outpatient facilities and approximately 1:2 for inpatient facilities.

Upon completing all three phases and receiving PJD approval, the project is placed on the priority list. The IHS uses the HFCPS to add new proposals for outpatient and inpatient facility construction proposals to its priority list. Once a project is on the priority list, it remains until it has been fully funded through Congressional appropriations.

Despite a deliberate effort to provide a fair and equitable system by which health facilities can be evaluated and ranked, there remain numerous problems and complaints about the system. For example, urban Indian health programs have not had access to this component of the IHS. Urban programs operate primarily in leased facilities, which have proven inadequate in most cases. A facility renovation needs assessment was conducted by the IHS for all urban programs funded under Title V which revealed significant facility needs.

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Smaller facilities are not considered under the current system. Many tribes have tried and failed to get their proposals on the construction priority list, for a variety of reasons. Because the existing HFCPS is “workload-driven”, larger communities are more likely to have their facility needs addressed than smaller communities. Several of the IHS Areas have not had any health care facilities constructed under this system.

Congress has attempted to address the shortcomings of the existing system, by creating new authorities for alternative approaches. The Indian Health Care Improvement Act attempts to address the facility construction needs of smaller projects, not able to compete on a national scale for the IHS facility priority list through two different programs. While these programs were authorized close to ten years ago, the “Small Ambulatory Grant Program” and “Joint Venture Construction Program” had not received Congressional funding until Fiscal Year 2001.

The draft language in the proposed bill to reauthorize the Indian Health Care Improvement Act (IHCA), includes revisions to Title III requiring IHS to report annually on the total requirements of IHS, tribal, urban (I/T/U) health care facilities renovation, expansion, and new construction.

### ***3. Appropriations Process and History***

The Indian Health Service receives annual appropriations through Congressional Interior Appropriations Acts, including operational dollars and specific annual facility construction appropriations.

The Indian Health Service has conducted its own assessment of facility replacement needs. The current average age of an IHS facility is 32 years. In 1994, the Indian Health Service estimated the costs involved to bring all existing IHS, tribal and urban health care facilities up to standards competitive with the larger health care industry. In this analysis, the IHS estimated that it would require an additional \$3.2 billion to bring all existing I/T/U facilities up to competitive levels.

<b>IHS Health Care Facilities Average Age in Years</b>	<b>Number</b>	<b>Average Age</b>
Hospital Buildings	47	32
Health Center Buildings	50	28
Health Station Buildings	45	28
Other Institutional Excluding Health Centers/Stations	118	25
Office Buildings	171	34
Other Buildings	421	33
Staff Quarters	1,420	26
All building (excluding quarters)	858	32

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Unfortunately, the IHS receives far less than what is needed, addressing only a fraction of the total construction need. Several approaches have been implemented over the last thirty years to prioritize facility replacements and new construction. Every approach has its advantages and disadvantages. Since 1989, the IHS has used a revised "Health Facilities Construction Priority System" (HFCPS) to identify and list the ten highest priority inpatient facilities, ten highest priority outpatient facilities and the required staff quarters projects, reporting these data to Congress for appropriations consideration.

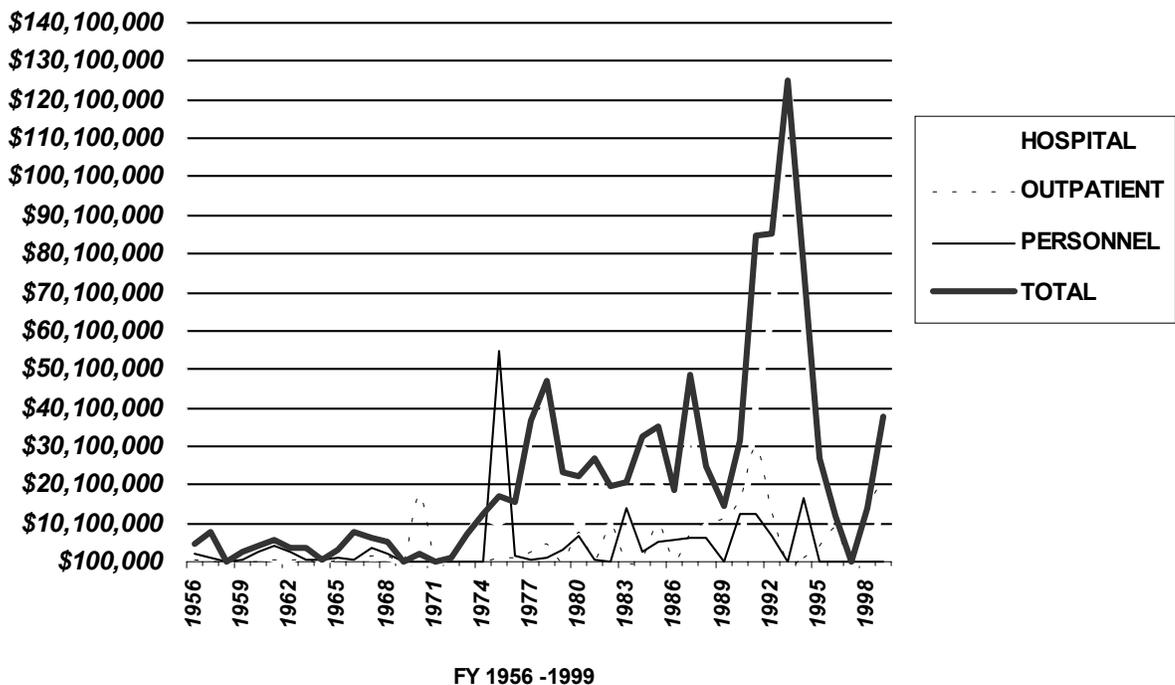
While the HFCPS was developed in an effort to apply fair, equitable criteria and standards to the question of which community will see a new or replacement health care facility in Indian Country, the system has been identified by Congress and by tribal leadership as in need of review and improvement.

The annual appropriations from Congress to IHS for facilities construction have fluctuated dramatically over the years. It has fluctuated from \$32 million in Fiscal Year 1984, dropping to only \$14 million in Fiscal Year 1989, and up as high as \$134 million in Fiscal Year 1993. In 1994, the Indian Health Service estimated the cost of bringing all facilities up to levels competitive with the private sector. In the 1994 analysis, the estimated total need was \$3.2 billion. Currently, there are 26 approved construction projects on the facility construction list or "pipeline". Of these 26 projects, the estimated cost for all projects ready to be funded is approximately \$900 million. Of the remaining projects, which still must complete all required paperwork prior to funding, the estimated cost may exceed \$600 million.

The history of Congressional appropriations for health care facility construction reveals the impact Title III of the Indian Health Care Improvement Act has had beginning in 1976. The dramatic fluctuations in appropriated levels from year to year, suggest that construction appropriations are primarily dependent upon Congressional support for individual projects on the priority list, as opposed to a sustained level of investment for capital construction.

## NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS

### INDIAN HEALTH CARE FACILITIES HISTORY OF APPROPRIATIONS



Construction appropriations for hospitals represent far greater investment than funds appropriated for outpatient facilities according to these data. The sharp increase in hospital appropriations between Fiscal Years 1992 and 1995, is primarily due to the funding of the replacement hospital, Alaska Native Medical Center in Anchorage, Alaska, a relatively large project in comparison to other years.

#### 4. *Alternative Funded Construction*

While it was not within our charge, the Workgroup wanted to point out the significant contribution toward construction of Indian health infrastructure that is made by tribes and urban programs outside the funding of the IHS. Tribes and urban programs have leveraged private financing and secured support from other federal, non-IHS resources to construct hospitals and clinics. A 1999 Roundtable sponsored by IHS "Discussion and Analysis of Future Options for Indian Health Care Facility Funding" profiled several of these innovative approaches.

Data provided by the IHS at the Anchorage meeting of this Workgroup revealed that in terms of both space and dollars, tribes contribute more than the IHS for health facility construction across the U.S.

**NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS**

**Tribally Funded Facility Estimates By Area (1996-2001)**  
**(excludes renovations and remodels)**

Tribal Space Constructed (thousands of GSM)

Aberdeen	4.5	(2.0%)		
Alaska	34.0	(15.2%)		
Albuquerque	4.8	(2.1%)		
Bemidji	39.0	(17.4%)		
Billings	0.27	(0.1%)		
California	49.0	(21.9%)		
Nashville	15.0	(6.7%)		
Navajo	0.0	(0.0%)		
Oklahoma	35.0	(15.6%)		
Phoenix	17.0	(7.6%)		
Portland	22.0	(9.8%)		
Tucson	3.2	(1.4%)		
Total Space Constructed by Tribes			223,455 Sq Meters	
Total Space Constructed by IHS			70,000 Sq Meters	

Tribally Funded Construction Costs (millions of dollars)

Aberdeen	\$3.05	(0.8%)		
Alaska	\$87.3	(24.3%)		
Albuquerque	\$9.28	(2.6%)		
Bemidji	\$72.6	(20.2%)		
Billings	\$0.25	(0.1%)		
California	\$69.5	(19.3%)		
Nashville	\$15.1	(4.2%)		
Navajo	\$ 0.00	(0.0%)		
Oklahoma	\$43.2	(12.0%)		
Phoenix	\$13.0	(3.6%)		
Portland	\$42.1	(11.7%)		
Tucson	\$4.4	(1.2%)		
Total Non-IHS Construction Costs			\$359,729,808	
Total IHS Construction Costs			\$171,248,000	

Source: Indian Health Service 2001

## **II. OVERVIEW OF PROCESS**

### **A. Meetings**

#### **1. Agenda and Purpose**

The Indian Health Service's Facilities Appropriation Advisory Board selected Workgroup members from nominations presented by tribes and tribal organizations. Tribal representatives from the Navajo Area, Anchorage Area, Bemidji Area, Aberdeen Area, Tucson Area, Phoenix Area, California Area, Portland Area, Nashville Area, Oklahoma Area, Albuquerque Area were selected to participate (See Appendix). Indian Health Service staff were also represented at each of the meetings. Participants were asked to fund their own travel and hotel accommodations to attend these meetings. The IHS provided funding for an outside facilitator to assist in organizing the meetings and moving the Workgroup through their list of objectives.

To date, the Workgroup has met with I.H.S. staff and Workgroup facilitators four times during 2001 (February, April, August and October) and once during January of 2002. Each meeting lasted two days. Detailed agendas and minutes for each meeting are attached to this report. The Workgroup met on the following dates and locations to address the agenda topic indicated below:

<b>Date</b>	<b>Location</b>	<b>Agenda Topic</b>
February 22, 23, 2001	Rockville, MD	Orientation & Planning
April 26, 27, 2001	Reno, NV	Needs Assessment
August 8, 9, 2001	Anchorage, AK	Priority Criteria
October 25, 26, 2001	Tulsa, OK	Integration of Systems
January 24, 25, 2002	Sacramento, CA	Finalize Recommendations

#### **2. Review and Discussion of Issues**

Each of the meetings provided focused discussion to meet our objectives for that session. Our first meeting provided an outline of how we planned to divide the activities and charges to the group as follows:

Rockville Meeting (Feb. 01) "Orientation and Planning": This meeting provided time for all the workgroup participants to receive orientation from IHS Headquarters staff on each of the major components in the IHS facilities construction program, including needs assessments, facility construction priority system, alternative programs such as joint venture, small ambulatory clinics, dental clinics, and other programs. In addition, the workgroup discussed an approach to addressing each of their charges sequentially over the next four meetings. Participants examined their personal schedules and made commitments for future meeting dates and locations.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

Reno Meeting (April 01) “Needs Assessments”: The Workgroup was provided an orientation on the “Health System Planning” (HSP) software that was developed by IHS to document health services and facilities needs of a community based upon certain standard data. The HSP offers several options that make it attractive. It is fairly easy to apply, it utilizes population data and not utilization data, it factors local available resources and applies generally accepted utilization rates for various types of primary, secondary and tertiary services.

Obstacles to meeting the above Needs Assessment objectives were identified and addressed. These included such things as the lack of resources available to complete Master Planning for all 12 areas; coordination and collaboration between all Areas/Tribes; including smaller tribes and groups who do not fall within population limits of Health System Planning (H.S.P.); the HSP does not identify facility needs for wellness centers, elder care, etc.; effectively communicating a needs assessment plan to Tribes and Congress; Tribal/I.H.S. and I.H.S./Federal collaboration/coordination; and prevention/treatment conflicts; and American Indian/Alaska Native demographic issues.

Anchorage Meeting (August 01) “Priority Criteria”: A detailed description of the principles and processes of the existing Health Facility Construction System was provided to the Workgroup. The Workgroup focused upon the purpose of a new rating criteria as well as specific principles upon which a new rating criteria system should be built. The Workgroup believes that the purpose of a new criteria should:

- reflect the intent behind the current proposed amendments to P.L. 94-437;
- contain multiple lists which are developed for different needs;
- provide rank ordering lists for congressional funding;
- fix flaws in the current system; and
- better allocate money for a variety of different areas/needs.

Specific rating criteria principles were discussed by the Workgroup which emphasized that each area to participate on a “relative need basis”; facility consideration be based on the Area Master Plan, (utilizing the HSP model); the system maintain a “defined” list(s) of national facility priorities; factors (standards) be amended to be more inclusive beyond current system; isolation (or lack of access) be a factor, based upon distance to primary care, distance to emergency room services and lack of “access” to services (economic); population numbers and workload thresholds be reduced to be more inclusive; a measure for tribes unable to access local services will be developed; cost efficient collaborations be encouraged (incentives) where appropriate; full consideration for tribal facilities be afforded.

Following these preliminary discussions the Workgroup participated in a facilitated workshop to identify the components of the ranking criteria. This initial brainstorm was then sorted, categorized and weighted. These criteria are reflected in the recommendations section of this report.

Tulsa (October 01) “Integration of Systems”: The focus of the Tulsa meeting was to address if and how other alternative construction programs of the IHS should be

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

integrated into the facility construction priority ranking system. In an effort to provide recommendations on an integrated system, the Workgroup participated in presentations and discussions regarding: Ambulatory Care Groups; Options for Federal Funding of Health Care Facilities Construction Projects; the Joint Venture Program; the Small Ambulatory Care Program; and the Indian Health Care Delivery Demonstration Project.

In addition, the Workgroup utilized this meeting to re-visit the draft Needs Assessment and Priority Criteria recommendations developed in earlier meetings. A model of how the current recommendations would impact facility ranking was examined. The Workgroup then proceeded to identify findings, brainstorm on the development of an integrated system and then develop specific recommendations.

## **III. FINDINGS**

### ***A. Needs Assessment Findings***

The Workgroup found that there is currently no regular method for determining the complete facility needs which exist today across all I/T/U programs. Needs assessments are conducted by IHS on an “as needed” basis. The existing needs assessment methodology applied to IHS and tribal programs is no longer current, and may not always take into consideration facilities not secured by tribes through the Indian Self-Determination Act process. Urban Indian health programs are not a part of this system. An urban facilities needs assessment was conducted using different criteria many years ago and is no longer reliable.

The IHS currently has in place the following methodologies with which it can respond to requests for conducting facility needs assessments:

- **Facilities Master Plans:** There is currently no single IHS Facilities Master Plan that describes existing infrastructure, capital expansions and needed improvements for IHS and tribal facilities. In 1998, the IHS requested each of the 12 Areas to update existing Master Plans. Most Areas did not have the resources to complete this request and there was a lack of uniformity in approach and standards to complete the task.
- **The Health Care Facilities Construction Priority System:** Section 301 of the IHCIA directs the IHS to identify planning, design, construction and renovation needs for the 10 top priority inpatient care facilities and 10 top priority outpatient care facilities and submit these needs through the President to Congress. As described earlier in this report, there are three phases for construction proposals to compete within. Phase III requires the full scale planning study, through the Program Justification Document (PJD).

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- **Facilities Planning Forecasting Guidelines:** This is a document used by IHS Area Offices to develop workload forecasts required in developing plans. The Forecasting Guidelines were used prior to the broader availability of the HSP. The guidelines identify basic workload variables, such as: primary care visits; inpatient admits; inpatient days; coronary care days; intensive care days; deliveries; newborn days; surgery cases; and renal dialysis treatments.
- **Facilities Data Base:** The Facility Data System (FEDS) contains real property and deficiency information for all IHS and participating tribal facilities. It contains data obtained from facility condition surveys. Managers are provided with a means for allocating resources for maintenance and improvement (M&I) projects. FEDS data and facility age are both used in the existing Priority System as an indicator of existing facility condition.
- **Facilities Condition Survey:** The FCS is conducted by engineering and other personnel familiar with assessing and evaluating the physical plant to identify deficiencies, including physical condition deficiencies, code and standard violations, and space improvement requirements. A report is generated from the survey that lists the deficiencies and the recommended corrective actions and costs. These data are incorporated into the FEDS which is then used to establish and prioritize future projects to correct deficiencies.

A newly emerging option for conducting community based services and facility needs is the Health System Planning (HSP) software which was developed under contract through the IHS. This new HSP has been applied in a few areas and within local service areas.

### ***B. Priority Rating Criteria Findings***

Existing limited systems described above support the data requirements to operate the Health Facility Construction Priority System (HFCPS). In addition to the FEDS data, the age of facility, isolation and user workload data are important in the current system. The current priority system was developed in 1989 and applied to proposals in 1990 primarily for the purpose of generating the 10 top inpatient facilities and 10 top outpatient facilities for the priority list provided to Congress.

The existing system is based upon certain basic assumptions and principles that drive the formula. Those assumptions are:

- Each Area has a health care delivery plan
- People requiring services are being served somehow
- Small facilities may be uneconomical and inefficient
- Once on the priority list project stays until funded
- Outpatient care has highest IHS priority
- The Priority System will be applied to both tribal and IHS proposal
- Space is indicator of facilities capability to handle program requirements
- Federal policies, regulations will be utilized
- Where no definitions or standards, criteria exist, IHS HQ will develop
- PJD is required for placement on the priority list

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

Based upon these assumptions and principles the IHS has applied weighted factors with data generated through the HFCPS system, including relative space needed, existing space, workload, FEDS, age of facility and nearest alternative resource. Distance is weighted based upon the minimum standard that inpatient facilities should be within 90 minutes of travel time, and outpatient care should be within 30 minutes travel time. The outcome of this system has been health facilities that serve larger Indian populations in more rural settings. Smaller, rural Indian communities have not been well served by this system. While the assumptions favor outpatient care, the allocation of construction funds indicate much greater priority on inpatient facilities. The total number of facilities constructed for outpatient centers is greater than for inpatient centers, however the dollars appropriated for outpatient construction is dwarfed in comparison to spending on inpatient construction.

### ***C. Integrated System Findings***

The lack of flexibility in the HFCPS has in large part contributed to the increase in alternative construction programs, as tribes find different and faster ways to build or replace clinics and hospitals. Tribal initiated changes to the IHCIA have created new construction options.

Alternative (off-list) construction programs operating through the IHS include the following:

- **Youth Regional Treatment Centers (YRTC):** The Anti-Drug Act of 1985 amended the IHCIA to authorize one YRTC for each IHS Area, with the exception of California and Alaska Areas which authorizes more. Subsequent amendments were provided to include more than one YRTC for Phoenix Area. These centers were to provide inpatient treatment to AI/AN youth in each area. Currently all areas, except California and Phoenix have acquired and operate YRTC's.
- **Joint Venture Program:** Enacted as an amendment to IHCIA under Section 818, the Joint Venture Program authorizes Congress to appropriate recurring funds for increased staffing, operation and equipment for new or replacement facilities constructed with non-IHS funding acquired by tribes. If services are provided through the IHS, the tribe must provide a 20 year no-cost lease of the facility. Since 1991, when it was first authorized, only two tribes were selected to participate. Recently, Congress has provided additional funding for Joint Venture Programs and the IHS has restricted tribal proposals to only those currently on the existing priority list. Two additional tribes are expected to secure agreements under this recent funding opportunity.
- **Small Ambulatory Program:** This program is only available to tribes contracting to operate a facility under PL 93-638 the Indian Self-Determination Act. The facility may not be owned or operated by the IHS, nor can it have been previously owned by IHS and later transferred to the tribe. The program must be operated separate from a hospital and must not have received any prior funding through the IHS priority list. There are certain stipulations which make this program difficult to assist truly "small"

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tribal communities. These stipulations include: (1) Serve no less than 500 eligible Indians annually; and (2) Provide ambulatory care in a “service area” not having less than 2,000 eligible Indians (unless located on an island). These stipulations leave out many small tribal communities who could not compete under the HFCPS and who cannot meet the required service population for the Small Ambulatory Program. In FY 2001 Congress provided \$10 million for this program and the IHS has received 62 proposals.

- Indian Health Care Delivery Demonstration Project: The IHCA was amended to provide Section 307 which authorizes the IHS to consider demonstration projects which test alternative methods of providing health services, providing priority to nine (9) identified facilities which had been slated for closure by the IHS. The cut-off date for projects to be considered was in September of 1995. No funds have been appropriated for this project.
- Non Service Funds for Renovation: Section 305 of the IHCA authorizes the IHS to accept renovation or modernization of IHS facilities by any tribe, and as needed to provide additional equipment and staffing support for the facility. The IHS has not received notice from any tribe under this program and does not currently have a priority list for this program.
- Dental Clinics: Congress has provided specific funding to tribes for the construction or expansion of dental units and funds to purchase equipment for new tribal facilities. Up to \$1 million annually has been provided.

The Workgroup noted that Congressional language accompanying the recent appropriations for the Joint Venture Program required that projects on the existing Priority List be given priority for these funds. Rather than an alternative to the Priority List, the Joint Venture Program provided a way for projects to move more quickly off the Priority List and signaled an interest by Congress to ensure all construction projects with long lasting funding implications (recurring costs) were given equal scrutiny. Funds provided for the Small Ambulatory Program did not require consideration of projects already on the Priority List.

## **IV. RECOMMENDATIONS**

### **A. Needs Assessment Recommendations**

Many of the recommendations proposed by the Workgroup regarding Needs Assessments are based upon the assumption that the Health System Planning (HSP) Process software can be easily applied in a fair, consistent manner across all 12 Areas.

#### **4. Health System Planning**

**ISSUE:** There is currently no routinely administered system for assessing the facility needs in the Indian health delivery system serving IHS, tribal and urban (I/T/U) programs. Without a consistent method of assessing need, it is difficult if not impossible to define the real need in terms that are reliable and credible. The IHS invested in the development of a software system designed to identify service and facility needs for defined populations. The system has been implemented in only a few areas, but has proven to be a useful and effective tool. The system is not driven by workload data. It factors in local available alternative resources and applies generally accepted utilization rates for service types to best describe needed services and facilities for a population. This latest technology is available to Indian health systems, but should be uniformly applied in order produce a national picture of need.

**RECOMMENDATION:** We recommend that the IHS in consultation with the I/T/U's implement the "Health System Planning" (HSP) software/model be applied locally to determine the services and facilities required in individual service areas nation-wide. Based upon these community-specific or service area specific HSP analyses, a community specific Master Plan will be generated to quantify the costs associated with the construction of expanded, replaced or new facilities.

#### **5. Area Master Plans:**

**ISSUE:** Assuming that each community will engage in the HSP method of establishing a definition of services and facilities needs, these data can then be integrated at the Area level to produce a Master Plan. The importance of integrating these data must be emphasized. A Master Plan will better develop the HSP to show multi-tribal systems, regional levels of care and referral systems. It will also help to establish relative priority within an Area for construction and development of new services. It will prevent IHS construction funds from supporting the spontaneous construction of facilities that are not rational or warranted within the context of the Area-wide service delivery system.

**RECOMMENDATION:** We recommend that the results of the community-specific HSP services and facilities analyses be integrated into a regional Area-wide Master Plan for each of the 12 IHS Areas, in consultation with I/T/U's, which will describe the services and facilities for the Area, the required expanded, replacement or new construction for

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needed facilities and estimated costs associated with those projects, roughly estimated based on facility type and size.

### **6. HSP Adaptability for Smaller Communities:**

**ISSUE:** Currently the HSP makes certain planning assumptions about each community it examines. For example, the HSP may not be formulated to accurately examine the services and facility needs for populations of 100 to 500 residents. American Indian and Alaska Native communities in these rural, remote settings are not served well under the existing IHS system for establishing priority for construction funding. While the HSP is, in the view of the Workgroup, ready to be applied to rational service delivery areas and/or smaller communities, it may need to be adapted to ensure it truly reflects the needs of rural, remote communities. However, the Workgroup felt that making these adaptations for communities of less than 100 users may not be productive in light of the overall demand for services and facilities nation-wide.

**RECOMMENDATION:** We recommend the IHS invest in making the necessary modifications to the current HSP technology, so that communities of not less than 100 users can be included in the updated HSP analysis.

### **7. Space Deficiency for Core Services Only:**

**ISSUE:** Currently the HSP model examines core services that are traditionally included in basic health care delivery systems, ie., outpatient medical care, outpatient dental care, laboratory services, pharmacy services, mental health counseling, inpatient services, etc. The HSP model does not include templates to calculate needed services and facilities for other alternative aspects of health delivery, ie, wellness centers, long term care, traditional Native healing. While the Workgroup is supportive of the IHS eventually making these alternative services a part of the HSP, the Workgroup recognizes that without agreed upon “standards” for these new services, communities could potentially skew the results of the HSP by loading in extra square footage for alternative or “off-template” services. This would unfairly elevate the relative need of one community over another based upon the inclusion of these off-template services. It is important that this system compare “apples to apples” and “oranges to oranges”. Therefore, until such time as adequate tribal consultation has occurred to reach national consensus on standards for off-template services, only those existing core services within the HSP should be applied for establishing a national Needs Assessment and Priority Criteria system.

**RECOMMENDATION:** We recommend that calculations for space deficiency which results from application of the HSP will be based only upon those “core health services” currently within the template formula of the HSP. We caution the expansion of these templates until there is consultation and agreement regarding space requirement standards for off-template services.

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### **8. Off-Template Services and Future Planning:**

**ISSUE:** Services considered to be “off-template” within the HSP system are still important to the long term health and wellness of AI/AN populations. For example, as the AI/AN population ages, long term care services will become more and more important. It is important that off-template services be defined and standards developed through a rational consultation process that weighs I/T/U input, demographic data and is supported or verified through industry standards if such exist. Without close care and protection for the integrity and reliability of off-template standards, the Workgroup fears that the results of a national Needs Assessment will become suspect and therefore discounted by Congressional decision-makers.

**RECOMMENDATION:** We recommend that the IHS invest in a long term plan to develop formula for templates for alternative services not currently described in the HSP to be applied in the future. These alternative services could include, but not be limited to, wellness centers, long term care facilities, traditional medicine, alcohol and substance abuse treatment, preventive services, etc.

### **9. Unit Price Budgeting:**

**ISSUE:** There are a variety of ways for calculating the total estimated costs for needed facilities. It will be important for the integrity and reliability of the national Needs Assessment that some method for standardized unit costs that are regionally sensitive be utilized. Using a regionally sensitive standard unit cost will enable quick calculations of construction projects based upon the level of facility space identified through the HSP. Again, the Workgroup is concerned that a national Needs Assessment should reflect some level of comparable standards applied to health services and facilities needs across Indian Country.

**RECOMMENDATION:** In accordance with acceptable IHS Standards, we recommend that regionally appropriate unit price budget calculations be utilized within each of the Local and Area Master Plans to calculate preliminary estimated costs associated with construction projects.

### **10. Repair vs. Replacement:**

**ISSUE:** As a part of the national Needs Assessment it will be important to identify not just new and replacement construction needs, but also repair or renovation needs as well. A means for determining when a project warrants repair and when a project warrants replacement is necessary. Such a mechanism should be applied across the board in a standard formula.

**RECOMMENDATION:** We recommend that industry standards be followed for determining repair or replacement options, such that if repair estimates exceed 75% of replacement estimates, projects may be recommended for replacement.

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### **11. Non-IHS Funding:**

**ISSUE:** This Workgroup found that non-IHS dollars far outpace the investment of IHS dollars in the construction of health care facilities in I/T/U settings across the country. Investment of non-IHS resources should be encouraged and leveraged to provide expanded resources and facilities. It is important to understand the significance of these alternate resources and track these investments over time.

**RECOMMENDATION:** We recommend that each Area Master Plan include a thorough description of the space and dollars for new or replacement construction of tribal and urban health facilities constructed with non-IHS dollars, from 1996 to present.

### ***B. Rating Criteria Recommendations***

**ISSUE:** One of the most important aspects of conducting the Needs Assessment utilizing the HSP model, is to produce comparable data so that proposals can be compared to one another in a fair manner. Assuming the HSP will produce data that can fairly be compared from project to project, the Workgroup developed the following specific recommendations for conducting both Area and National priority ranking. The Workgroup understands that the IHS may need to respond to Congress soon regarding new construction projects on the priority list. The following recommendations should be taken into consideration before any future priority ranking occurs. Also, because only IHS and tribal projects are considered under the current construction priority system, some method for ranking urban Indian projects separately for consideration of funding under the Urban Indian health authority has also been considered.

#### **RECOMMENDATIONS:**

- We recommend that the IHS NOT apply the existing HFCPS to add facilities to the priority lists. Rather, we recommend a new system be implemented for any future priority ranking based upon the specific proposals and recommendations contained in this report.
- The Workgroup decided that competing facilities should be ranked according to the following two categories: (1) Urban Indian facilities will be ranked with other Urban Indian facilities when requesting consideration for Title V funding; and (2) Tribal and I.H.S. facilities will be ranked against each other when requesting consideration for funding under the construction line-item of the I.H.S. budget.

- Proposed Priority Criteria and Criteria Weighting:

**1. Master Plan Required:** To be considered for the priority list, a project must be included in its respective Area Master Plan.

**2. Relative Criterion Weights:** The Workgroup recommends that the following criteria be used with the corresponding relative weights shown:

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<u>Criteria</u>	<u>Proposed Weighting:</u>
a. Facility Deficiency Scores	35
b. Isolation	10
c. Documented Barriers	10
d. Health Indicators	15
e. Innovation	15
f. Type of Facility	<u>15</u>
Total Possible	100

### **3. Justification and Explanation of Proposed Criteria:**

- a. **Facility Deficiency Scores:** These scores weigh the greatest in the proposed criteria. The score reflects the gap between existing space and required space as determined through the HSP analysis. Factors such as facility age, condition of facility, and user population are included in this analysis.
- b. **Isolation:** This criterion refers to the physical distance of the population to the nearest health center or hospital. To receive full weight for this criterion a community would need to be 60 miles or more from the nearest hospital and 30 miles to the nearest outpatient facility, or removed from that facility by air travel or water. The closer the alternative facilities, the less weight assigned.
- c. **Documented Barriers:** This criterion could be calculated in a number of ways, and is included to cover “access barriers other than geographic distance”, such as economic barriers, cultural barriers, transportation barriers, racial discrimination other socio-economic factors. Developing objective measures that can be documented and consistently applied will be a challenge.
- d. **Health Status Indicators:** Health status indicators represent a new and important addition to facility construction ranking criteria. This criterion can also be calculated in a number of ways. For purposes of discussion, we have presented two options, one looking at infant mortality rates as a ratio to national U.S. rates, and “Years of Productive Lives Lost” (YPLL) as a ration to U.S. rates. There may be other, more appropriate measures, such as those under development at Johns Hopkins University which will incorporate a range of both morbidity and mortality data.
- e. **Innovation:** Significant weight is assigned to this “new” criterion proposed by the Workgroup. Additional work is needed to define the types of innovations which might qualify for added weight. For discussion purposes, we have provided examples of innovative steps which could provide incremental points in this area. This could include investments of non-IHS dollars in the project, collaboration with other tribes or consortia, or regional partnerships.
- f. **Type of Facility:** These factors will be consistent with the standards for services and facilities reflected in the HSP. The Workgroup wanted to provide a mechanism to prioritize smaller outpatient facilities over inpatient facilities and support community-based prevention and primary care. This criterion

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

would be applied based upon a grid that assigned values inversely to projects based upon size. The larger the project the lower the value. The smaller the project the greater the value.

### **Defining Thresholds and Values for Facility Types**

- i) Medical Center or regional inpatient facilities
- ii) Small Hospital and other local inpatient facilities
- iii) Primary Care Health Center and other comprehensive outpatient settings;
- iv) Health Station and other solo practitioner stations

## ***C. Integrated System Recommendations***

These recommendations are based upon an assumption that Congress will provide recurring construction appropriations, which can be allocated consistent with the proposed recommendations below.

### **1. Universal Priority List:**

**ISSUE:** Rather than develop multiple lists for different types of facilities, ie outpatient list, inpatient list, etc., the Workgroup proposes that a universal priority list be developed. Only through a universal priority list can priority ranking occur which shows priority of outpatient services over inpatient services for example. While Congress may exercise its option to pull from the list those inpatient facilities in a ranked order, it is important to have a universal list that reflects the priorities across Indian Country.

**RECOMMENDATION:** The Workgroup recommends that priority ranking be conducted for all of the many construction programs proposed in each of the 12 Area Master Plans of the IHS, not just the 10 top outpatient and 10 top inpatient facilities. From this ranking a universal national priority list will be produced that includes all projects in the Area Master Plans, including inpatient, outpatient, dental, joint venture, small ambulatory clinics, staff quarters, regional youth treatment centers and other proposals in the Master Plan. New services that are currently outside the existing HSP template, such as long term care, wellness centers, etc., will be added to this priority list as developed and accepted under an amended national HSP format.

### **2. National Priority List for Congressional Consideration:**

**ISSUE:** The Workgroup proposes that there be two levels of review and allocation of resources for construction projects. Those projects which include increases in recurring costs (such as increased staffing and increased operation/maintenance) should fall under the review and approval of the U.S. Congress for construction appropriations. Other “one-time” construction projects that do not include increases in recurring costs for the IHS budget should be handled separately, through Area allocations.

**RECOMMENDATION:** From the Universal List, all projects which have implications for recurring costs (staffing, operations) will be compiled in a National Priority List for

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

consideration for Congressional appropriations. This may include inpatient facilities, outpatient facilities, staff quarters, joint venture projects, etc.

### **3. Area Priority List:**

**ISSUE:** The Workgroup is proposing a greater role and involvement of I/T/U's through the Area Offices of the IHS to better plan and implement their Master Plan's through the allocation of construction funds for one-time projects that do not include increases in recurring costs.

**RECOMMENDATION:** All construction projects that do not involve new or expanded staffing or increased recurring commitments from the IHS, will be deferred to the Area Priority List in each of the 12 IHS Areas. These may include regional youth treatment centers, dental clinics, small ambulatory care clinics, or other innovative or alternatively funded projects. Area ranking of these projects will be conducted based upon the proposed criteria.

### **4. Area Percentage Allocation:**

**ISSUE:** The Workgroup is proposing that each of the 12 IHS Areas receive an allocation of the annual construction appropriations for purposes of making allocations to one-time projects that are included in the Area Master Plans. This method for allocating resources to the Areas will expand the importance of the Area Master Plan and the rational allocation of construction dollars for priority projects. The Workgroup expects that such a system will enhance Area planning and regional health delivery coordination.

**RECOMMENDATION:** We recommend that a percentage of annual construction appropriations be allocated to each of the 12 Areas according to a need-based formula. Each Area will determine for themselves how best to allocate these Area construction dollars according to the Area Master Plan and Area Priority Lists, including but not limited to, construction costs, debt relief, loan guarantees and other innovative construction strategies.

### **5. Amendments to Authorizing Statutes:**

**ISSUE:** Existing provisions in the Indian Health Care Improvement Act currently prevent the application of many of our recommendations. For example, the small ambulatory clinic program is restricted to only communities with 2,000 or more population. This definition of a "small clinic", is too restrictive and eliminates many truly small American Indian and Alaska Native communities from being eligible for funding. Existing law that requires the IHS to provide the 10-top outpatient and 10-top inpatient facilities on the construction priority list, is not consistent with the Workgroup proposals that all facilities be rated and presented in total.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**RECOMMENDATION:** We recommend that IHS seek Congressional amendments to authorizing statutes to eliminate threshold restrictions on categorically authorized and funded facility construction programs, such as small ambulatory clinic restrictions to communities with 2,000 users or more, to be consistent with existing HSP formula and proposed integration recommendations.

## **DAVIS/BACON WAIVERS**

**ISSUE:** A major drain on limited construction dollars for new and replacement health facilities in AI/AN communities is the federal requirement that the Davis/Bacon Act govern IHS funded construction. In many rural, remote areas where IHS construction dollars are used to build health facilities, the Davis/Bacon requirement means that construction costs are drastically inflated and construction funding is provided to contractors from outside AI/AN communities. Rather, the Workgroup proposes that these requirements be waived for IHS funded construction so that construction revenues can stay within AI/AN communities and costs can be reduced.

**RECOMMENDATION:** The Workgroup is recommending that Congress provide a waiver of the Davis Bacon Act for all construction funded through the IHS appropriations. This waiver can be achieved through either authorizing statute or through annual stipulations on the Interior Appropriation Acts.

## **V. APPENDIX**

### **A. Meeting Agendas, Minutes and Resource Material**

- February 22, 23, 2001 Meeting Agenda, Minutes and Handout Materials
- April 26, 27, 2001 Meeting Agenda, Minutes and Handout Materials
- August 8, 9, 2001 Meeting Agenda, Minutes and Handout Materials
- October 25, 26, 2001 Meeting Agenda, Minutes and Handout Materials
- January 24, 25, 2002 Meeting Agenda, Minutes and Handout Materials

### **B. Other Materials**

**ROCKVILLE MEETING**  
**FEBRUARY 22, 23, 2001**

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**Facilities Needs Assessment Criteria Workgroup**

**Agenda**

**February 22, 23, 2001**

**12300 Twinbrook Metro Plaza**

**6<sup>th</sup> floor IHS Conference Room**

**Rockville, Maryland**

THURSDAY, FEBRUARY 22

- 8:00 Refreshments
- 8:30 Welcome  
Ervin Chavez, Chairperson, FAAB
- 8:45 Opening Remarks  
Michael Trujillo, MD, Director or designee  
Indian Health Service
- 9:00 Introductions from the group – Ervin Chavez
- 9:15 Status of Indian Health Facilities Legislation – Mike Mahsetky, IHS  
FY 2000 Appropriations Language  
Indian Health Care Improvement Act Reauthorization
- 10:00 Break
- 10:15 Charge to the Group and Overview of Timeline and Tasks – J. Kauffman
- 10:30 Setting Workgroup Ground Rules – J. Kauffman
- 11:00 Review Briefing Book – J. Kauffman
- 12 Noon Lunch on your own
- 1:30 Background on IHS Facilities Issues
  - Facilities Program
  - Existing Methodology
  - Dental, Joint Venture and Small Ambulatory Clinics
- 2:30 Break
- 2:45 Teambuilding Exercises – J. Kauffman
- 3:15 Break-out Groups to Brainstorm Approaches/Resources/ Structure
- 4:30 Recess

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

FRIDAY, FEBRUARY 23

8:00	Refreshments
8:30	Review Agenda – J. Kauffman
8:45	Teambuilding Exercises
9:00	Developing a Workgroup Plan – J. Kauffman
10:00	Break
10:15	Setting a Schedule for Future Meetings of Workgroup – J. Kauffman
1:00 PM	Adjourn

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

### **Minutes of the IHS Facilities Needs Assessment and Criteria Workgroup Meeting February 22, 23, 2001 Rockville, Maryland**

#### Workgroup Participants Present:

Mr. Benny Atencio  
Ms. Helen Bonnaha  
Mr. Rick Boyce  
Mr. Robin Carufel  
Mr. Ervin Chavez  
Ms. Sara De Coteau  
Mr. Gary Markussen

Mr. Darrel Juan  
Mr. Jayme Longbrake  
Chairman Arlan Malendez  
Mr. Jerry Simone  
Mr. Rod Smith  
Mr. Ed Wilson  
Ms Carmelita Skeeter

Workgroup Participants Absent: Mr. John Guinn; Mr. Anthony M. Guteirrez; Mr. Myron Littlebird; Mr. Adrian Stevens.

IHS Staff Present: Lee Robison; Bill Smith; Jose Cuzme, Bruce Chilokowsky, Randy Gardner, Luana Reyes, Gary Hartz and Michael Mahsetky.

Contractor Present: Jo Ann Kauffman, Kauffman and Associates, Inc.

#### SUMMARY

The Workgroup conducted its first organizational meeting in Rockville, Maryland on February 22, 23, 2001. It included introductory remarks from Ervin Chavez, Chairperson of the IHS Facilities Appropriation Advisory Board (FAAB) and from Luana Reyes on behalf of IHS Directory, Michael Trujillo. An orientation of the overall facilities needs assessment and priority criteria system was provided by Lee Robison and other staff from the IHS. The meeting was facilitated by IHS contractor, Jo Ann Kauffman.

The “charge” to the group is to develop specific recommendations for consideration by the IHS FAAB in regard to revisions to the existing systems which assess the facilities construction needs in Indian Country, and the manner in which these needs are ranked against each other for construction funding competition. Specifically, the Workgroup has been asked to provide recommendations regarding:

1. The criteria to be used for establishing and annually reviewing the need for facilities construction in Indian County; and
2. The criteria and relative weight of each criteria to be used to prioritize among competing projects; and
3. Strategies for dealing with (coordinating and/or integrating) the prioritization needs of the various health care facilities construction programs (inpatient facilities; outpatient

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

facilities; dental units program; Joint Venture Program; Small Ambulatory Program; and the proposed Loan Guarantee Program (437), etc.

### **EXPECTATIONS**

When asked to describe expectations for the Workgroup, the participants offered the following:

- Funding to construct outpatient for tribes. More outpatient can be built, with funds for one hospital.
- Methodology based on Health status to get facilities where most needed.
- Ways to eliminate backlog.
- Understand area-specific uniqueness (i.e. California)
- Find a better distribution method so more communities get “something”, not just winners/losers. More flexibility.
- Maximum options and flexibility – opportunity to have input to Congress.
- Address each tribe at Grassroots level, not paper/politics level. Tribal focus in criteria.
- Fair formula to assess actual needs locally – will assure funding to those with greatest need.
- How to find equity with various “tracks” small amb., joint venture, priority list). What about tribe without resources to partner/finance? Do not want to see projects on list now slowed down by new formula.
- There should be a component where every tribe fits. Tribe needs more, better information to know where they fit in.
- Maintain existing Priority List and not disrupt list with our new system. Find system that encourages tribes to support total list.
- How to help Indian communities, get new facility.
- Need “tools” to show Congress true need for facilities construction.
- Advocate for small tribes and direct care tribes.
- Concentrate on Priority List.
- Find way to define urban Indian construction program, priority, etc.
- Develop organized approach to everything coming (437 Reauthorization). Be ready when Congress acts.
- Incentives for inter-tribal coordination.
- Find ways to reduce government estimates/cost for construction (i.e. Eliminate division) (Template design)
- Justify new monies together not fight over small funds.
- Make sure we understand local need but the group needs to address overall, national needs, not our local programs.

### **GROUND RULES**

The Workgroup agreed on consensus that the following points will be observed during our times together:

- Start – End on time

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- No side conversations
- Share expectations today
- Respect various divergent opinions
- Document and follow-up on all meetings
- Operate on Consensus
- Regularly check-in with everyone about expectations – reality check.
- Try to stay on schedule

### **HFCPS DISCUSSION**

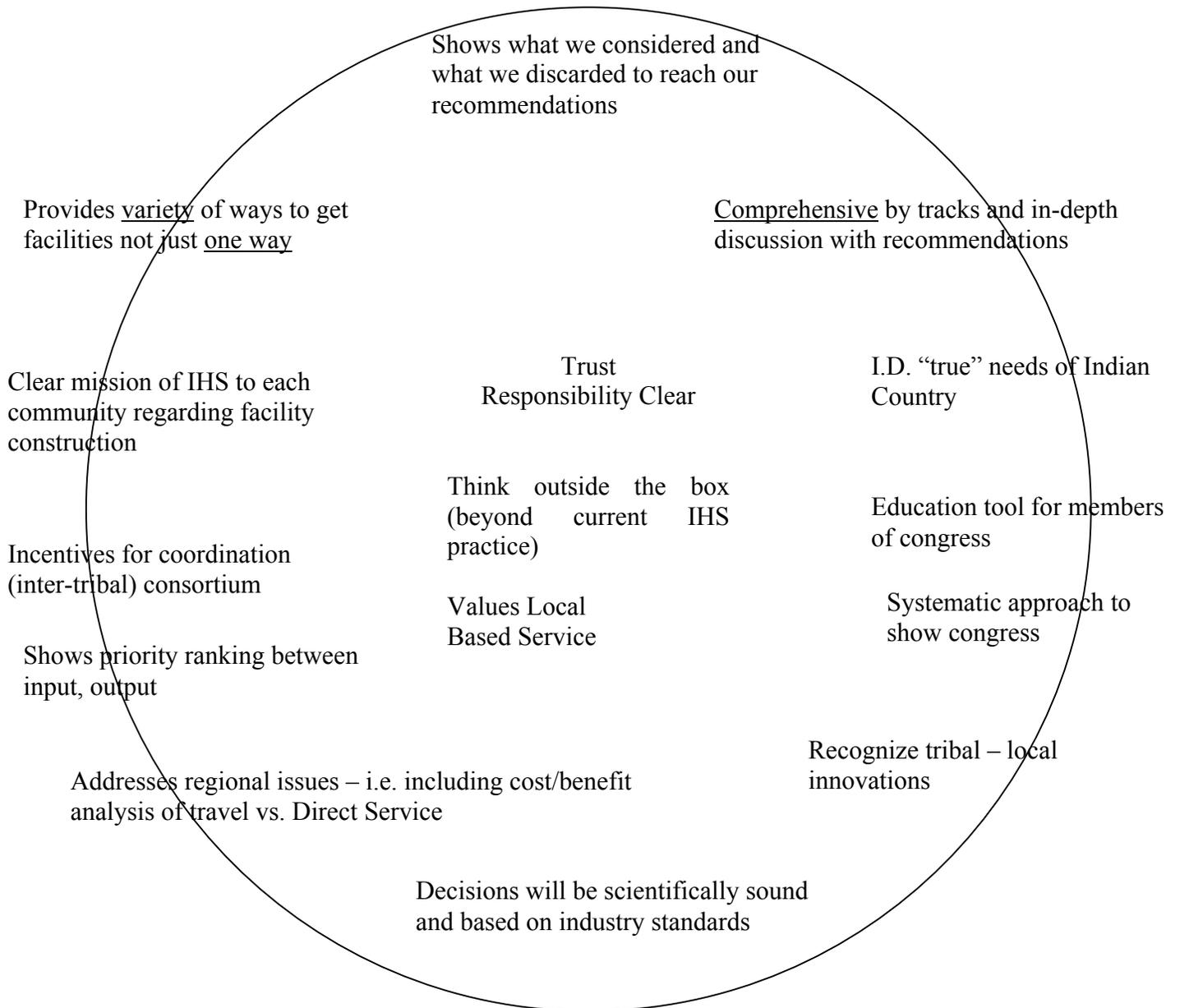
After detailed presentations about the IHS facilities needs assessment process, the Health Facilities Construction Priority System (HFCPS), Joint Venture Program and Small Ambulatory Care Program the following points were made by participants during the discussion:

- Consider setting aside funds regularly to replace facilities in 20-30 years.
- What is the tribal input and involvement at Phase I and Phase II?
- Look at “Point System”. Points for no facility vs. points for existing facility and which ranks higher. Shouldn’t you just figure the need for facility first before ranking?
- Problem of holding onto land designation when waiting 10-15 years on List or Phase III.
- How significant is the Area Health Care System Plan to individual proposal?
- Seismic factors not in current criteria – but could be in FEDS (Facility Eng. Deficiency System)
- Points given for added workload to facility due to urban IHS beneficiaries.
- What is impact of eligibility definition on facility justification? Also impact of undoc/illegal aliens emergency use of facilities.
- Does compartmentalization of types of facilities cause dis-jointed services at local level? Line items help lobbying interests.
- Tribes who can afford to build their own clinics vs. tribes relying on Federal Direct Services
- Tribe are losing who aren’t contracting

**NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS**

**“VICTORY” OR “SUCCESS” AT THE END OF OUR EFFORTS**

*WHAT WILL OUR FINAL REPORT ON THE NEEDS ASSESSMENT AND FACILITIES CRITERIA LOOK LIKE IDEALLY?*



***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

The Workgroup completed an exercise to identify the “strengths, weaknesses, risks and benefits” of this particular Workgroup’s efforts to undertake this charge. The group identified the potential risks and benefits of a “successful” effort on their part. The analysis is as follows:

<p><i>STRENGTHS OF OUR GROUP</i></p> <ul style="list-style-type: none"> <li>• Vast intelligence in the group</li> <li>• Cross section representation</li> <li>• Leaders, experience</li> <li>• Commitment</li> <li>• Outspoken, well-spoken</li> <li>• Dedication to the job</li> <li>• IHS resources, knowledge</li> <li>• Knowledge of Workgroup</li> <li>• Linkages (budget, FAAB, 437)</li> </ul>	<p><i>WEAKNESSES OF OUR GROUP</i></p> <ul style="list-style-type: none"> <li>• Will still face limited knowledge, data</li> <li>• Limited time</li> <li>• New administration</li> <li>• Overcoming our own community-specific agenda’s and working for the good of the whole system</li> </ul>
<p><i>RISKS OF SUCCESS</i></p> <ul style="list-style-type: none"> <li>• Report not accepted by tribe(s), IHS, congress</li> <li>• Congress overwhelmed by comprehensiveness of changes – goes status quo</li> <li>• Regression in funding or political support</li> <li>• OMB opposition</li> </ul>	<p><i>BENEFITS OF SUCCESS</i></p> <ul style="list-style-type: none"> <li>• Clear vision</li> <li>• Message</li> <li>• Hope for tribes previously left out</li> <li>• Giving congress data, tools, process</li> <li>• More funding (new)</li> <li>• Education tool</li> <li>• Tribal ownership</li> </ul>

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**Proposed Schedule of Outcomes and Timeline for Workgroup**

<p><b><u>Meeting #1</u></b> Rockville – February 22, 23, 2001</p> <p><b><i>Introductory</i></b></p> <ul style="list-style-type: none"> <li>• Understand Charge to group</li> <li>• Orientation of Systems</li> <li>• Plan Work and Timeline</li> </ul>	<p><i>Meeting #2</i> Reno – April 26, 27, 2001</p> <p><b><i>Needs Assessment</i></b></p> <ul style="list-style-type: none"> <li>• Orientation of IHS systems/data</li> <li>• Analysis</li> <li>• Options to consider</li> </ul>
<p><i>Meeting #3</i> Anchorage – Late July, 2001</p> <p><b><i>Priority Criteria</i></b></p> <ul style="list-style-type: none"> <li>• Orientation</li> <li>• Analysis</li> <li>• Options</li> </ul>	<p><i>Meeting #4</i> Tulsa – October 25, 26, 2001</p> <p><b><i>Integration of Other Programs</i></b></p> <ul style="list-style-type: none"> <li>• Orientation</li> <li>• Analysis</li> <li>• Options</li> </ul>
<p><i>Meeting #5</i> San Diego – January 2002</p> <p><b><i>Draft Plan</i></b></p>	<p><i>Meeting #6</i> Rockville – March/April 2002</p> <p><b><i>Final Report</i></b></p>

**TASKS**

- Inform tribes what we’re doing. Share information.
- Get feedback from tribes about these issues.
- Revisit each track we are considering (in-depth)
  - How it works
  - Brainstorm options
  - Factors used in prioritization and develop new/revised
- Study SDS as option/model for Needs Assessment for health facilities

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- Set schedules, mail minutes out,
- Communicate ideas, concerns with JoAnn or Lee
- List current barriers to get facilities data and perceptions
- Hear success stories
  - Private sector
  - tribal
  - urban
- Bio information of Workgroup shared with others

### **FROM IHS**

- Oklahoma M & I formula – resource allocation (info) as an option;
- SDS information to the Workgroup;
- HSP demonstration for the Workgroup;
- How IHS defines populations. (data person at next meeting)
- Health status data/reliability trends report(s) available on site.

### **NEXT MEETING**

The next meeting will be April 26, 27 in Reno, Nevada. We will ask the IHS to prepare for presentations on the Needs Assessment procedures and other options for assessing facilities needs.

MEETING ADJOURNED: February 23, 2001 at 12 Noon.

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

MEETING HANDOUTS ARE AVAILABLE. IF YOU WISH TO HAVE THESE HANDOUTS, PLEASE CONTACT LEE ROBISON

Email: [Lee.robison@mail.ihs.gov](mailto:Lee.robison@mail.ihs.gov)

Address: Needs Assessment Handbook

% Lee Robison

IHS/OEHE

12300 Twinbrook Parkway, Suite 600A

Rockville, MD 20852

# **RENO MEETING**

**APRIL 26, 27, 2001**

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**AGENDA**

**IHS Facilities Needs Assessment and Criteria Workgroup  
Meeting to Address Issues of “Facility Needs Assessments”**

**April 26, 27, 2001**

**Reno Hilton Hotel**

**Reno, Nevada**

**Thursday, April 26, 2001**

- |         |  |
|---------|--|
| 8:00    | Refreshments   |
| 8:30    | Welcome and Introductions  |
| 8:45    | Overview of the Agenda and Tasks to be Accomplished  |
| 9:00    | Orientation on Existing IHS Needs Assessment Process<br>Priority System (When We Run It)<br>PJD for a specific facility (one location process)<br>Deep Look Survey (Engineering Survey done every 5-6 years)<br>Other Systems for Discussion (?) |
| 10:00   | Break  |
| 10:15   | Discussion of Options to Conducting Needs Assessments  |
| 12 Noon | Lunch  |
| 1:30    | Orientation on the Health System Planning Software   |
| 2:30    | Discussion on HSP  |
| 3:00    | Break  |
| 3:15    | Discussion of Options to Conducting Needs Assessments via HSP  |
| 4:30    | Recess   |

**Friday, April 27, 2001**

- |      |              |
|------|--------------|
| 8:00 | Refreshments |
|------|--------------|

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

8:30	Review Agenda and Time/Tasks
8:45	Facilitated Discussion to identify Needs Assessment Objectives
9:30	Facilitated Discussion to identify Needs Assessment Obstacles
10:00	Break
10:15	Facilitated Discussion to identify Needs Assessment Strategies
12 Noon	Lunch
1:30	Identify Advantages/Disadvantages of Selected Options or Strategies
2:30	Break
2:45	Development of “Draft” Needs Assessment Recommendations
3:45	Review Schedule and Define Next Steps
4:30	Adjourn

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**Indian Health Service Facilities Criteria Workgroup  
Meeting Minutes  
Reno , Nevada  
April 26-27, 2001**

**Thursday, March 26**

The meeting was called to order at 8:30 AM. The meeting was facilitated by John Bird with Kauffman and Associates, Inc.

**Present:**

Arlan Melendez, Chairman, Reno-Sparks NV  
Helen Bonnaha, Area Health Board Services, Navajo Nation Rep, Kayenta AZ  
Ed Wilson, Rep, Concho, OK  
Darrell C. Juan Project Manager Tohono O'odham Nation, AZ  
Lee Robison, Indian Health Service  
Ervin Chavez, FAAB, Navajo Nation  
Rick Boyce, Facilities Director, ANTHC, Anchorage AK  
Rod Smith, NW Portland Indian Health Board , Portland, OR  
Jose Cuzme, Indian Health Service  
Carmelita Skeeter, Executive Director, Tulsa, OK  
Benny Atencio, Albuquerque Area, Santa Domingo, NM  
Doreen Welsh , Tribal Council Person, Colorado River Indian Tribes, Parker, AZ  
John Guinn, Director of Facilities, Bethal, AK  
Jerome Simone, Executive Director, UIHS, Trinidad, CA  
Anthony Guterrez Tribal Council, AA, Bernalillo NM  
Sara DeCoteau, Sisseton-Wahpeton Sioux Tribe, Sisseton, SD  
Gary Markussen, CA Indian Health Service Board, Blue Lake, CA (day two only)

Lee Robison provided an overview of the agenda and tasks to be accomplished at this meeting . There was a suggestion to reduce the volume of paper information to make it easier for people to use. Lee gave a presentation on the IHS facility needs assessment process. Facilities assessments are conducted “on an as needed basis”. They are done when the need arises. See handout of presentation by Mr. Robison

It was pointed out that it is difficult to expect Congress to fund facilities replacement or construction when there is not regular information about the need for these funds.

Mr. Robison then talked about the priority system. Only facilities that reach the Phase III level have had a thorough needs assessment completed. The current priority system only looks at facilities that can handle 4,400 primary care visits per year. This excludes small clinics and health stations. This was de facto policy of Indian Health Service.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

In 1994, IHS developed an estimate of the cost to bring its health care facilities inventory up to modern standards as a part Clinton Administration “Health Care Reform Initiative.” Although this was not a full need assessment, it provides an estimate based on population. It estimated the cost at \$3.1 billion total facility need system-wide. It was solely a headquarters exercise. This request died with the rest of the Health Care Reform Initiative, probably because of the sizeable cost. Mr. Robison stated that if the need can be documented, the chances may be better for keeping the door open.

Jose Cuzme gave a short presentation explaining the relationship between Primary Care Provider visits and health services space and staffing . See attached document.

### **Lunch Break**

Presentation on “Health System Planning” (HSP) software. Gerald provided background on need and development of the HSP software. User population was used instead of number of patient visits because number of patient visits was a difficult target to project and kept changing. Many new facilities that were built based on patient visits were too small by the time they opened.

Another reason for developing this system was that facilities would sit on the priority list for ten or more years. During that time, needs changed and populations changed

Gerald demonstrated the system, projecting out numbers and space requirements for the year 2010, based on selected services provided at a facility.

It is hoped that in the future, the HSP will include a component that will project the staffing needs based on the workload projections and staffing according to space. This RRM (Resource Requirements Methodology, the second part of the software system) would provide the specific number of staff (FTE) that are projected to be needed.

One of the drawbacks of the system is that it was designed for the tribes currently on the priority list, which excluded many of the smaller tribes. Gerald talked about the modifications that are used or necessary to account for this.

### **Summary of Group Discussion:**

Discussion of options to conducting needs assessment: April 26, 2001

- What determines need? What are we going to evaluate?
- How can what is already available in terms of resources be rolled into this process?
- What resources are available at Indian Health Service Area Level/Tribes? What is commitment of tribes to the plan?
- How is need calculated? Does it take into account travel for isolated tribes? Is determined by Health Status?

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- What are the factors/criteria for identifying and documenting need for facilities? For unmet need?
- How do we account for regional differences regarding new facility construction?
- How do we come up with a national formula that includes those differences?
- Do we need regional formulas/criteria? There was discussion about this and the outcome was that it is better to have a national plan that sets standards/criteria that are built on common ground across tribes.
- What is definition of facility? Does that mean a hospital, clinic?? Or an access point to health care? A distribution point for resources?
- There was discussion about the need to look at populations not being served now to determine where the greatest unmet need is.
- There was discussion around the work of this group with the conclusion that the task is to develop a plan that is inclusive of ALL Indians in the nation.
- The question was raised as to whether we have to wait for facilities currently on the priority list to be constructed before implementing any new plan.
- The current formula for determining need is based on population, existing space in relation to required space, and the isolation factor.
- There was discussion about the joint venture option between IHS/tribes. The question was raised as to whether tribes that have resources to enter into joint venture should have priority for existing federal resources. Is that fair and equitable?
- There was a suggestion that perhaps a two step process needs to be developed. One is based on need only and the other second process would be for those that can provide tribal funding and enter into joint venture.
- Discussion about the current priority list. There are currently 9 priority lists for facility construction. The question was raised as to whether another system would be more feasible. There was discussion about the number of lists and the general feeling of the group is that there should only be one or two lists.
- Every tribe, both large and small has specific needs. A local planning process is needed to determine those local needs.
- There was discussion about the current way things have done. The group feels that criteria should be developed based on current conditions/needs instead of what has been done in the past.
- The group feels that all Indians, both reservation and urban need to be included. The focus should be on unmet need regardless of size of tribe, location, reservation, or urban.

### **Discussion of Possible Recommendations:**

- Every man, woman, and child who is enrolled/eligible should have access to health care and adequate facilities.
- There was discussion about the active user criteria. Should it be removed and use patient visits/workload criteria instead? The group felt that both need to be used.
- There was a suggestion that carryover funds be rolled over into next Fiscal Year, if they have already been appropriated.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- The concept of isolation needs to be defined. Is it physical isolation or does it also include economic isolation. The group thinks both need to be part of the definition of isolation.
- There was a recommendation that tribes or programs that are forced into debt in order to construct facilities should not automatically fall out of consideration for resources. They are still left with a large debt to repay and that needs to be considered.
- Recommendation to explore partnerships to help build facilities. Loan guarantees to help get funds for construction and partnerships with HUD to build staff housing are some areas that were suggested. The issue of rentals was discussed and the problems of size and Federal guidelines were identified as obstacles.
- Facility Deficiency should be one of the factors in determining need. Space, lack of quality space, and age of facilities should be considered as factors. It was suggested that there needs to be a model or standard that applies to both larger and smaller facilities.
- The economic status and poverty levels of tribes/Indian populations should be a factor.
- Regarding the issue of isolation, it was suggested that cost effectiveness should be a factor. What is most cost effective: the distance to the next level of health care? The next level of IHS care? Or the next level of any care?

### **Comments regarding option to use HSP to conduct needs assessment:**

- Very helpful. It helps judge size, staffing, equipment all on one program (note: all costs for equipment are not included in program)
- Has no bearing on quality of existing space. It has to be used in conjunction with some system such as FEDS.
- Does not address populations below 2500-3000 people.
- This is a computer program. As such it does not have the human touch. It must be accompanied by an area wide Master Plan that assesses health in that area.
- There is a way to get existing Tribal Health and other programs into system (substance abuse, mental health programs, etc.).
- This system is beneficial for assessing the overall unmet need as per the work of this group. There is no need to create a new system for the purposes of the work of this group.
- Other services need to be accounted for that are not traditional Indian Health Service services. These include all areas of substance abuse (including detox), long term care, elder day care, traditional medicine, assisted living, wellness centers, and psychiatric beds/units.
- The need of a formula to assess standard need was discussed.
- An area wide Master Plan has to be conducted prior to or in conjunction with using the HSP. The master plan would flush out unmet needs.

**Friday, April 27, 2001**

The group defined needs assessment objectives, obstacles and strategies as follows:

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

### **Objectives:**

- 1) To document/justify to Congress unmet need in terms of space, facilities, equipment,
- 2) and staffing.
- 3) To develop a needs assessment process that is inclusive of all Tribes/Indian people (the group felt it was important to use the ITU concept) regardless of size or location.
- 4) To incorporate areas into the planning process for space and facilities for services not traditionally provided by Indian Health Service such as fitness/wellness centers, traditional medicine, long-term care, assisted living, elder care, psychiatric units/beds, other types of “prevention” or “rehab” services, holistic health services.

### **Obstacles:**

1. Available resources (to do Master Planning)
2. Coordination/collaboration between all Areas/Tribes.
3. Smaller Tribes/groups (Alaska/Nevada) that don't fall within population limits of the HSP. How will these be included.
4. Communication with Tribes, Congress, etc. to get buy-in for plan.
5. HSP does not identify space requirements for programs such as wellness centers, elder care, etc. listed above. These need to be included.
6. Turf Issues-that become obstacle for effective collaboration/coordination. Tribes/HIS, IHS/other federal agencies, and conflicts between prevention and treatment.
7. Numbers -of Indians (is this undercounted?)
  - Urban / Reservation
  - What numbers does Congress look at. Census data?
  - What about descendants, mixed, intertribal, not enough to enroll in any one tribe.

### **Proposed Strategies:**

1. Each Area Office will conduct a Master Plan prior to or in conjunction with using the HSP to assess need.
2. Where HSP falls short (re: population) HSP needs to be tweaked, modified to include these smaller populations.
3. Need to develop a set of guidelines, criteria, standards to include these smaller groups.
4. A communications/PR strategy needs to be developed to inform and communicate plan and process to Tribes/congress to get buy in. Use National forums such as NCAI, Self governance conference, NIHB.
5. Incorporate existing space deficiencies into overall unmet need.
6. Assess cost of redirecting dollars from direct service into meeting space/facility/other needs.
7. Documentation of space need for Wellness Centers needs to be included.
8. Once needs are established and documented, a letter to Congress from the group will be written.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

9. How will cost be estimated once space needs are determined? Will the IHS cost estimation process be used?
10. Guidelines need to be established that guide when to renovate or build new.
11. Resource allocation for facilities- group can make recommendations.

### **Criteria for updating, monitoring of space requirements:**

1. It is computerized, electronic, web based.
2. Master Plan is broken into components that can be updated every two years.
3. Master Plan updated every 5 years.

### **Action Items for the Workgroup:**

1. Draft guidelines for populations under the 2500-3000 threshold that have been developed will be shared by Jose Cuzme.
2. The need for wellness centers will be defined/documented.
3. KAI will format and write the narrative introduction for the plan
4. Lee Robison will distribute outline of existing criteria for the group to look at when considering future criteria. Lee will get these to JoAnn to include with next mail-out.
5. Jose Cuzme will do the same with the list of IHS constructed facilities in last 10-12 years. This will be sent to Jo Ann to include in the next mail-out.
6. Headquarters will request inventory of Tribal Facilities cost from each Area. This will include square footage, cost, planning, design, construction, and equipment.
7. A letter to Congress from this group will be developed by JoAnn. Ervin will call her to brief her. Lee will develop a letterhead for the work group.

### **Draft needs assessment recommendations:**

1. Use HSP in conjunction with Master Plans to conduct needs assessment.
2. Numbers 1, 2, 3, 5, 7, 9, 10 from list of strategies.
  - Each Area Office will conduct a Master Plan prior to or in conjunction with using the HSP to assess need.
  - Where HSP falls short (re: population) HSP needs to be tweaked, modified to include these smaller populations.
  - Need to develop a set of guidelines, criteria, standards to include these smaller groups.
  - Incorporate existing space deficiencies into overall unmet need.
  - Documentation of space need for Wellness Centers needs to be included.
  - How will cost be estimated once space needs are determined? Will the IHS cost estimation process be used?
  - Guidelines need to be established that guide when to renovate or build new.
3. Number 3 from list of objectives.
  - To incorporate areas into the planning process for space and facilities for services not traditionally provided by Indian Health Service such as fitness/wellness centers, traditional medicine, long-term care, assisted living, elder care, psychiatric units/beds, other types of “prevention” or “rehab” services, holistic health services.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

4. Needs assessment will include aspect of appropriate debt relief for ITU's that were forced into debt to construct. How far back? Maybe to include remaining debt?

### **Brainstorm of Criteria in preparation for Anchorage meeting:**

Our meeting in Anchorage will focus the priority system and the development of preliminary recommendations regarding competing projects and ranking. Once need is established what criteria will be used to set priorities? Some areas to consider before the Anchorage meeting:

- 1) One list or 9 lists?
- 2) Priority given in this order
  - a. outpatient health centers/preventive services
  - b. Intermediate Health Centers (day surgery, etc)
  - c. Hospitals?

### **Factors to consider:**

- Facility and space deficiency
- Isolation, both physical and economic
- User population or workload?
- Economic Status
- Health Status- needs to be defined. How measured? Look at indicators used now by IHS. Look at Alaska Rural Primary Care Facility Needs Assessment.
- Urban clinics that serve large numbers from different tribes (such as Reno-sparks)
- Demographics
- Local Initiative Factor
- Level of Need Funded
- Matching Funds- if matching funds are provided , should there be some sort of weight given to that in prioritizing? These include Program matching dollars, 3<sup>rd</sup> party payments, and Tribal Discretionary Funds.
- Will staffing dollars be required if facility is built? For how long?
- Partnerships/consortiums between ITU in same area.
- Letters or evidence of support from community / tribe.
- Partnering with the community.
- Reviewing alternate services in community.
- Diversification of funding sources. IHS, tribe, community , foundations, etc.
- Good use of alternate resources.
- Resolution from tribes in Partnership to build.
- Program sustainability
- Benefits per dollar invested, health improvements per dollar invested?
- Recurring Cost rates.
- A vision of overall purpose of priority list and who will float to top of list according to the criteria we set. The ranking system has to be tested and evaluated to be sure expected/desired outcomes are being reached.
- Two lists? One for non-staffing, non-recurring costs. Another for staffing, recurring costs.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- Level of need required for each area.

There was a discussion about the dates for the next meeting in Anchorage, Alaska. The group is holding **August 8-10, 2001** as the dates that best work for everyone. The last day, August 10<sup>th</sup> will be for touring local facilities.

Adjourned.

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

MEETING HANDOUTS ARE AVAILABLE. IF YOU WISH TO HAVE THESE HANDOUTS, PLEASE CONTACT LEE ROBISON

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Address: Needs Assessment Handbook

% Lee Robison

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**ANCHORAGE MEETING  
AUGUST 8, 9, 2001**

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**AGENDA**

**IHS Facilities Needs Assessment and Criteria Workgroup  
Meeting to Address Issues of**

**“Facilities Priority Rating System”**

**August 8, 9, 2001**

**Marriott Anchorage Airport Courtyard Hotel - Anchorage, Alaska**

WEDNESDAY, AUGUST 8, 2001

- 8:00 Refreshments
- 8:30 Welcome and Introductions
- 8:45 Overview of the Agenda and Tasks to be Accomplished
- 9:00 Review of Actions/Recommendations of April Meeting
- 9:15 Overview of Population Statistical/Data Systems  
Dr. Stan Griffith, Clinical Informatist  
IHS Information Technical Support Center
- 10:15 Break
- 10:30 Orientation on Existing IHS Facility Priority System  
Lee Robison, IHS
- 11:30 Traditional Foods Luncheon with Alaska Native Tribal Health Consortium  
(ANTHC) Board of Directors
- 1:30 Developing “Fundamental Principles” for a Priority System  
Review of Existing IHS Principles  
Identifying New System Principles
- 3:00 Break
- 3:15 Developing Criteria that reflect new Principles  
Review of Existing IHS Criteria  
Identifying New Criteria
- 4:30 Recess

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

### **Thursday, August 9, 2001**

- 8:00 Refreshments
- 8:30 Review Agenda and Time/Tasks
- 8:45 Testing New Principles and Criteria to I/T/U Facility Reality  
Outpatient Facilities  
Inpatient Facilities  
Dental Facilities  
Staff Quarters  
Urban Health Facilities
- 9:30 Discussion
- 10:00 Break
- 10:15 Review Relationship of New Principles and Criteria to Needs Assessment  
Recommendation made in April
- 12 Noon Lunch
- 1:30 Discussion and Development of Cross-cutting Recommendations
- 2:30 Break
- 2:45 Finalize Recommendations to FAAB regarding:  
Needs Assessments  
Priority Criteria Principles  
Priority Criteria
- 3:45 Review Schedule and Define Next Steps
- 4:30 Adjourn

### **Friday, August 10, 2001 (OPTIONAL DAY FOR TOUR)**

- 8:30 Leave Hotel for Tour of Medical Center
- 9:00 Presentation by Rick Boyce, Deputy Director of Regional Facility  
Programs, ANTHC, Anchorage, AK
- 9:45 Presentation by John Guinn, Director of Facilities, Yukon Kuskokwim  
Health Corporation (YKHC), Bethel Alaska
- 10:30 Tour of Alaska Native Medical Center and Lunch

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**Indian Health Service**

**Facilities Needs Assessment and Criteria Workgroup**

**Minutes**

**August 8, 9, 2001**

**Anchorage, Alaska**

**Participants:**

Helen Bonnaha, Navajo Area Tribal Rep.  
Rick Boyce, Anchorage Area Tribal Rep.  
Robin Carufel, Bemidji Area Tribal Rep.  
Ervin Chavez, Navajo Area Tribal Rep.  
Sara DeCoteau, Aberdeen Area Tribal Rep.  
John Guinn, Anchorage Area Tribal Rep.  
Darrel Juan, Tucson Area Tribal Rep.  
Chairman Arlan Melendez, Phoenix Area tribal Rep.  
Jerry Simone, California Tribal Rep.  
Rod Smith, Portland Area Tribal Rep.  
Adrian Stevens, Nashville Area Tribal Rep.  
Ed Wilson, Oklahoma Area Tribal Rep.  
Carmelita Skeeter, (Tulsa) Urban Health Rep.

**Staff:**

Jose Cuzme, IHS Headquarters  
Lee Robison, IHS Headquarters  
Randy Gardner, IHS Headquarters  
Jo Ann Kauffman, KAI, Facilitator  
Stan Griffith, Presenter

**Opening:** Ed Wilson offered an opening prayer to start the Workgroup meeting.

**Summary of Discussion:** The meeting began with a review of the agenda and introductions from all participants. Jose Cuzme provided an overview of the status of IHS facility appropriations for Fiscal Year 2002. The Workgroup was invited to have a traditional Alaska Native lunch with the Board of Directors for the Alaska Native Tribal Health Consortium at their new hospital facilities in Anchorage. There was a brief review of the recommendations developed at the Reno meeting with regard to national Needs Assessments.

**Overview of Population Statistical and Data Systems – Dr. Stan Griffith:** Dr. Griffith was requested to make a brief presentation to the Workgroup, so that participants could have a better understanding of the relationship between utilization data and the current priority rating criteria used by the IHS. His power-point slides are attached to these minutes. In summary, Dr. Griffith address the following major sections in his presentation:

- How and which data get into the I/T/U information systems;
- How and which data flow to the national level;
- How do we use these national data?
- What issues affect our use of these data?
- The future.....

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

The majority of the data described in his presentation is generated through the “Resource and Patient Management System” (RPMS), primarily through the Patient Care Component (PCC). The RPMS is used by all IHS and most tribal systems, but not urban programs. These data are exported from local IHS and tribal service providers/clinics to Area repositories and then forwarded to a central HQ database. National data is used for the following purposes:

- Statistical reports;
- Outcome measurements
- Assessing and informing on data quality
- Monitoring Epidemiological trends
- Facility Needs Assessments

The two statistical reports used most often are (1) Workload Reports, and (2) User Population Reports. Both these reports are important factors under the current IHS facility construction priority rating system. The two most significant “issues affecting our use of these data” are:

- Lack of uniform data standards
- Data quality

The IHS data system was described as a “chain with many links”. Fixing just one link will not make the chain stronger if there are other links that are still weak. The IHS has established a “data quality assessment” (DQA) to make recommendations for improvement. These recommendations will need to improve all “links”, from the local data input, to the national data base level.

The discussion among the Workgroup included questions about the RPMS system itself and problems with the data. For example, clinic patients who reside outside the defined IHS “service area” are not counted with the “user population” and therefore not calculated into tribal allocations. There was also discussion about what measures were considered acceptable measures for “health status”. Does it make any sense to include health status indicators as one of several criteria for facility priority rating purposes? There was also discussion about the Workload Reports for inadequate facilities may provide numbers that appear too low, but would increase substantially with an appropriately sized facility and more providers. There was discussion as to whether the Health System Planning (HSP) software provides only a description of “what is needed” or if it also produced a description in the “gap in services/facilities”, such as a ratio of what is needed compared to what exists. That question was not answered and will require follow-up.

### **Orientation on Existing IHS Facility Construction Priority Rating System – Lee**

**Robison:** Lee provided an overview of the current IHS facility construction priority system (FCPS). A copy of his power-point presentation is attached to these minutes. Lee focused on two questions:

- What is the Priority System?
- What are the factors in the current system?

The current system was developed in 1989 and applied in 1990 primarily for the purpose of maintaining a 20-project priority list for Congress. Ten outpatient and ten inpatient facilities are included on the priority list. The priority system was conducted in three (3)

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

“phases” for purposes of evaluating and ranking competing proposals. Phase I and Phase II utilize easily obtained and verified data in a straightforward formula that ranks proposals. Phase III is a planning study called the “Program Justification Document” (PJD). Once a PJD is completed the project is placed on the priority list. There were several “basic assumptions and principles” made in 1989, that were supposed to drive the formula, but upon reflection may not have weighed significantly in its application. These assumptions include:

- Each Area has a health care delivery plan
- People requiring services are being served somehow
- Small facilities may be uneconomical and inefficient
- Once on the priority list, project stays until funded
- Outpatient care has highest IHS priority
- The Priority System will be applied to both tribal and IHS proposals
- Space is indicator of facilities capability to handle program requirements
- Federal policies, regulations will be utilized
- Where no definitions or standards, criteria exist, IHS HQ will develop
- PJD is required for placement on the list.

The “factors” and “data” used by IHS in applying formula were also described. In the first two phases, a straightforward formula is applied. Phase I and Phase II evaluations examine three areas (1) Relative Need Factor (required space to existing adjust space); (2) Absolute Need Factor (required space ‘minus’ existing adjusted space); and (3) Isolation (measured in distance to alternative services). The factors in Phase III were more in-depth, and produced detailed descriptions of types of services based upon the Area Master Plan and availability of nearby services, such as surgery, dental, radiology, etc. Phase III also looks at the need for space to house services and the availability of “alternate resources”.

The “fill-in-the-blank” forms used by IHS for Phase I and Phase II evaluations include requirements for the following data:

- Workload (inpatient days, primary care provider visits)
- Existing Space
- Facilities Engineering Data System (FEDS) Data (“scores” the facility condition)
- Facility age
- Nearest available alternative services

The Phase III data is much less “fill-in-the-blank” and more research and analysis. It includes data on workload; availability of space alternatives; and detailed review of existing facility.

Overall, the current IHS rating system applies minimum criteria for consideration. These minimum criteria include:

- Inpatient facility threshold of 15 beds Average Daily Patient Load (ADPL)
- Outpatient threshold of 4,400 primary care provider visits (PCPV) per year
- Existing space compared to required space (absolute need and relative need) is scored
- 60 miles to another inpatient facility (weighed against ability to handle workload)
- 20 miles to Emergency Services (assumes outpatient care is also available)

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

In summary, the current system is working for its intended purpose (to maintain a 20 project list). Funding has not kept pace with the need for facility construction. Congress is supportive of revisions to the current system that will meet tribal needs and will integrate alternative methods of facility construction. Development of Rating Criteria: The Workgroup used the basic information provided in the presentations, along with data and orientation provided at previous meetings to begin discussion about developing a revised “Rating Criteria System” for the IHS.

### **Purpose of the New Rating Criteria:**

- The new criteria will reflect the intent behind the current proposed amendments to P.L. 94-437
- Multiple lists will be developed for different needs
- Rank ordering lists will be provided for congressional funding
- Fix flaws in current system
- Better allocate money for a variety of different areas/needs

The following principles represent a foundation upon which a new system will be built.

### **Principles**

- Each area will be able to participate on a “relative need basis”
- Facility consideration will be based on the Area Master Plan, (utilizing the HSP model)
- The system will maintain a “defined” list(s) of national facility priorities
- Factors (standards) should be amended to be more inclusive beyond current system
- Isolation (or lack of access) should be a factor, based upon:
  - Distance to Primary Care
  - Distance to Emergency Room services
  - Lack of “access” to services (economic)
- Population numbers and workload thresholds will be reduced to be more inclusive
- Just because a tribe is near services doesn’t mean they can access ( a measure for tribes unable to access local services will be developed)
- Cost efficient collaborations are encouraged (incentives) where appropriate
- Full consideration for tribal facilities will be afforded

## **Proposed Criteria for Inpatient and Outpatient Facilities**

It was the decision of the Workgroup to only attempt to develop criteria for inpatient and outpatient facilities competing for construction funding. It was discussed that the ranking of those competing facilities would be based upon a scoring system built on the following criteria. Urban Indian facility requests will compete against other urban facility request for consideration on Title V funding. Tribal and IHS facility requests will compete

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

against each other for consideration of funding under the construction line-item of the IHS budget.

- Facility Deficiency Scores (to be developed)
  - Will include consideration for “zero space” scenarios
  - Age of current facility
  - Gap between current facility and required space
  - Condition of Facility
  - User Population (expanded interpretation)
- Isolation (measured by distance)
- Documented barriers to access to inpatient/outpatient services locally
- Health status indicators
- Must be on the Area Master Plan
- Innovation and Collaboration points
- Volume thresholds will apply by type of facility (these will be lowered to be more inclusive, but will apply basic planning principles for cost/benefit considerations as well – to be developed)
  - Outpatient (health station vs. primary care clinic)
  - Inpatient
  - Intermediate (day surgeries, swing beds, short-stay, etc)

### ***Discussion of Proposed Criteria***

The criteria cited above is proposed for outpatient and inpatient facilities competing for consideration for Congressional appropriations based upon a list provided by the IHS. The criteria above does not (yet) consider other projects, such as Staff Quarters; Small Ambulatory Clinics; Joint Venture Proposals; Innovative Proposals (replace by repair, AmEx in Portland, etc); Urban Indian Health Projects under Title V of P.L. 94-437; Dental Units or Regional Youth Treatment Centers. These must still be developed by the Workgroup and a proposal for integration or relation among and between systems remains to be considered.

Unless there are increased appropriations for facility construction, it is unlikely these new, revised criteria will provide relief to the many communities in need of new and replacement inpatient and outpatient facilities. There is currently a \$1.2 billion backlog of projects on the priority list. It will take 12 years (if Congress appropriates \$100 million each year) to complete the existing list. A clear picture of a communities chances of seeing new construction funding should be provided. The proposed criteria will provide threshold levels which are more flexible for various locations and community sizes, but which maintains some level of cost/benefit comparison.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

### **TULSA MEETING:**

The next meeting of the Facility Criteria Workgroup will be **October 25, 26, 2001 in Tulsa, Oklahoma**. Carmelita Skeeter will host the meeting at the conference room of the Indian Health Care Resource Center in Tulsa. Hotel arrangements will be coordinated by KAI and forwarded to all workgroup participants.

### **Objectives of the Tulsa Meeting:**

- Review the Needs Assess Recommendations from Reno
- Review Criteria Rating System
  - Weight factors for each criterion
  - Pair-wise comparison (weights)
- Define thresholds for types of facilities
- Brainstorm final report format
- Integration decisions and activities
  - Joint Venture
  - Small Ambulatory Clinics
  - Dental Clinics
  - Regional Youth Treatment Centers
  - Staff Quarters
  - Innovative Approaches (Replacement by Repair, AmEx in Portland)

**Meeting Adjourned**

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

MEETING HANDOUTS ARE AVAILABLE. IF YOU WISH TO HAVE THESE HANDOUTS, PLEASE CONTACT LEE ROBISON

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# **TULSA MEETING**

**OCTOBER 25, 26, 2001**

## **AGENDA**

### **IHS Facilities Needs Assessment and Prioritization Criteria Workgroup October 25, 26, 2001 Tulsa, Oklahoma**

#### **Thursday, October 25, 2001**

- |          |  |
|----------|--|
| 7:45 AM  | Pick-up at Hotel for Transportation to Meeting Site  |
| 8:00 AM  | Refreshments   |
| 8:15 AM  | Opening Prayer   |
| 8:20 AM  | Welcome and Introductions  |
| 8:30 AM  | Review Workgroup Progress Report – J. Kauffman <ul style="list-style-type: none"><li>• Facilities Needs Assessment Recommendations</li><li>• Prioritization Criteria Recommendations</li></ul>   |
| 9:00 AM  | Review Remaining Activities – J. Kauffman <ul style="list-style-type: none"><li>• Schedule of Remaining Meetings/Tasks</li><li>• Brainstorm Format for Final Report</li></ul>  |
| 10:00 AM | Presentation on Practical Application of Prioritization Criteria Recommendations – Lee Robison and Jose Cuzme  |
| 10:30 AM | Break  |
| 10:45 AM | Open Discussion on Priority Criteria Applications – J. Kauffman <ul style="list-style-type: none"><li>• Facility Deficiency Scoring</li><li>• Isolation Scoring</li><li>• Barriers Scoring</li><li>• Health Status Indicator Scoring</li><li>• Master Plan Scoring</li><li>• Innovation Scoring</li><li>• Threshold Parameters</li></ul> |
| 12 Noon  | Lunch  |
| 1:00 PM  | Norm Smith – Johns Hopkins University  |

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

2:00 PM	Pair-Wise Comparison Exercise – Rick Boyce
3:30 PM	Break
3:45 PM	Discussion of Scoring Criteria and Recommendations
4:30 PM	Recess for the Evening

### **Friday, October 26, 2001**

7:45 AM	Pick up at Hotel for Transportation to Meeting Site
8:00 AM	Refreshments
8:15 AM	Welcome Back and Review of Remaining Agenda
8:30 AM	Presentation of All Programs Other than Inpatient/Outpatient <ul style="list-style-type: none"><li>• Joint Venture</li><li>• Small Ambulatory Clinics</li><li>• Dental Clinics</li><li>• Regional Youth Treatment Centers</li><li>• Staff Quarters</li><li>• Other Innovative Approaches Currently Used</li></ul>
10:00 AM	Break
10:15 AM	Open Discussion <ul style="list-style-type: none"><li>• Pros/Cons to an Integrated System</li><li>• Development of Workgroup Recommendation Regarding Integration of Programs</li></ul>
12 Noon	Lunch
1:30 PM	Facilitated Brainstorm Session <ul style="list-style-type: none"><li>• Creating an Integrated System</li></ul>
3:00 PM	Break
3:15 PM	Development of Recommendations About the Integration of the Multiple Facility Construction Programs
4:25 PM	Closing Prayer
4:30 PM	Adjourn

*NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS*

**Indian Health Service Facilities Needs Assessment and  
Prioritization Criteria  
Workgroup Minutes**

**Tulsa, OK  
October 25, 26, 2001**

**Participants:**

Rick Boyce, Alaska Area Tribal Rep.  
Eddie Wilson, Okla. Tribal Area Rep.  
Benny Atencio, Albq. Area Rep.  
Carmelita Skeeter, Urban Rep.  
Sara DeCoteau, Aberdeen Area Tribal Rep.  
Jerry Simone, California Area Tribal Rep.  
Gary Markussen, California Area Tribal Rep.  
Rod Smith, Portland Area Tribal Rep.  
Jamie Longbrake, Aberdeen Area Tribal Rep.  
Adrian Stevens, Nashville Area Tribal Rep.  
Doreen Welch, Phoenix Tribal Area Rep.

**Staff:**

Jose Cuzme, I.H.S Headquarters  
Lee Robison, I.H.S Headquarters  
Randy Gardner, I.H.S Headquarters  
Pamela E. Iron, K.A.I Facilitator  
Norm Smith, Presenter  
Allison Binney, Guest, Hobbs, Staus,  
Dean & Walker,

Carmelita Skeeter led a tour of the new Indian Health Care Resource Center Facility. .  
(A sign in sheet was passed around)

**Opening:** Eddie Wilson offered an opening prayer.

**Summary of Discussion:** The meeting began with a review of the agenda and introductions from all participants. The agenda was modified to meet the speaker's schedule. Carmelita Skeeter invited the workgroup members to have Indian Tacos for lunch. She also thanked Eddie Wilson, Business Committee Member of the Cheyenne Tribe for providing the funds for the meal.

**Facilities Needs Assessment Recommendations:** The facilitator, Pam Iron presented each recommendation for discussion and consensus acceptance. The following changes were made:

1. # 3 and #4 are related and need to be in one statement
2. #6 –At the end of the sentence the statement “ defining what services or activities are needed.
3. # 7 was a question. The group changed it to the following statement, “ A standardize cost estimating system will be used that is accepted industry practices.
4. # 9 add alcohol/substance abuse

Benny Atencio recommended that all the OEH Area staff receive all the documents that have been produced by this workgroup.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**Proposed Criteria Recommendations:** The group reviewed the criteria. It was noted that the Facility Deficiency Score sub-groupings were not prioritized. The group decided that the best way to see if their criteria system that they were proposing was to apply weights to the criteria. The group discussed the Area Master Plan. They came to the conclusion that each Area must have a Master Plan and in order to be in the Priority list, the I/T/U must be in the AMP. Rick Boyce presented the Alaska Rural Primary Care Facility Needs Assessment. (Handout #1. He explained how to develop a schematic chart that would assign rankings or weights to the criteria. It factored when presented to criteria which one was the most important and how much more important on a scale from 1-9. Each member assigned a weight to each comparison. (Handout #2 is what the group came up with) This is a fairly straight forward system however when you have diversity in groups there is a greater possibility that one persons weight will cancel out another. This was a practice application of ranking or prioritizing the criteria against each other. A grid was put on the board, Rick led the discussion. Pam, Lee, and Jose calculated the weights. This was a lengthy process however it gave the group a feel for the types of decisions that have to be made when you do a prioritization of criteria.

**Practical Application of Prioritization:** Jose Cuzme made his presentation. He passed out Handout #3 entitled NEW PRIORITY LIST CRITERIA. He talked briefly about his paper and answered questions.

### **Ambulatory Care Groups (ACGs) presentation by Norm Smith, Senior Health Economist, CompCare, Consultant to John Hopkins Hospital.**

(presentation of Health Status) This presentation was to educate the group on a method to measure health status. Mr. Smith states that data is a must for planning. The ACG is a good method to use in measuring health status if you want to measure health status as having multiple aspects. He stated that many or even most types of analyses are not meaningful unless the data have been risk adjusted. Once data are risk adjusted to become meaningful information, solutions or approaches may be very different  
Questions ask:

1. On health status why does Indian Health Service compare their statistics with sites within the Area rather than nationwide? The staff will research this.
2. What does Indian Health Service use now? Health Status is not part of the criteria currently to determine facility need.

(contact information-<http://www.acq.jhsph.edu>; 973/360/0077; [nsmith1@csc.com](mailto:nsmith1@csc.com))

### **Options for Federal Funding of Health Care Facilities Construction Projects**

Lee Robison presented material on the programs authorized by congress. (Handout # 4) Options for Federal Funding of Health Care Facilities Construction Projects) He went over each one and answered question about them. He explained that in the past and presently Congress requires I.H.S. to report 10 hospitals and 10 outpatient facilities There are three-(3) phases- Phase 1 objective analysis; Phase 2 same thing

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

Phase 3-program justification document (PJD). Because this has not worked well, the tribes have gone to Congress and requested funds. Congress has approved other methods of funding as described in his paper. He highlighted several of the programs.

**96-270** - Construction dollars for treatment center

**Joint Venture program**-1 million and ½ to build a facility – tribe would build, I.H.S. would provide equipment and staffing. Warm Springs and Choctaw Poteau Facility were the first two built under this method. In the year 2000- five million appropriated-use funds or give priority to those who were on the health centers priority list. Funding this year-CFR has 5 million dollars additional dollars. There is a restriction- look at priority list and look at size.

**Small ambulatory care program**- In 2000 congress appropriated 10 million dollars. Stipulations under this program. May not have been owned or operated previously by I.H.S., size of facility, no less than 500 Indians, service area of 2000 population. Tribe must show that it can managed the project and Lee stated that in his opinion Congress is interested in funding outpatient facilities.

### **Indian Health Care Delivery Demonstration Project-**

**Replacement for equipment**-reoccurring base, increased to 16 ½ 5 million for use of new tribally built facilities.

**Dental facilities** – 1 million construct, repair dental facilities

### **Replacement for I.H.S facility**

It was stated that Oklahoma I.H.S had worked with tribes in the 1970's to build several outpatient facilities by the tribes getting loans to build the facility and the I.H.S would pledge the lease money for twenty years to repay the loan directly to the bank. Office Of Management & Budget (OMB) has implemented a process called Scoring that has changed some of the ways that facilities could be funded. It was stated that a study should be done on how this worked and reported to the group. The buildings are now paid for and owned by the tribes.

**How do we integrate this process?** The group brainstormed on the integrated system. Recommendation of the group-

Rank all of the facilities by priority criteria identifying by authorized programs. A spreadsheet could be used to show what authorized program that each one is eligible for. They wanted to be able to show Congress all the need. In addition they wanted to be able to respond to Congress if they said we want to see the top ten small ambulatory outpatient clinics. These would be pulled from the rankings. There was discussion on how to do the dental and quarters. The decision was to have them be part of the universe along with the rest of the facilities.

## **Overall process –**

Step 1 Development of Area Master Plan

Collect data-identify criteria

Standardization of Master Plan-must contain

a) Facility DS

b) Isolation

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

c) documentation of barriers, health status indicators

Step II National Master Plan

a) Enter the data into a database

Step III Prioritize using criteria

Step IV Project Description for readiness/PJD

### **Meeting dates**

January 24, 25, 2002 were chosen. The California tribal Reps requested that moving the meeting from San Diego to Sacramento be considered due to the fact that this was the town where California Rural Health Board was located and the I.H.S. Headquarters for California. They recommended that Kauffman & Associates contact Jim Crouch regarding hotels and meeting accommodations. They would inform CRIB of the intentions.

Gary Markussen pledged Salmon for the meeting. He is from Northern California.

The group wanted to leave the last meeting date open so that they could coordinate it with the FAAB Committee meeting to make the final report presentation to them.

### **ELEMENTS OF THE FINAL REPORT**

The group moved the Brainstorming on the final report to Friday morning. They were asked “What elements should be in the final report?”. They wanted an Executive Summary that references the meetings and documented the road that was taken. Use language that refers to “appropriate flexibility” and language that shows that the system was designed to be responsive to the tribes. They wanted the following items included:

1. The colored tribal funding chart that Jose Cuzme passed out at the Anchorage meeting included in the report.
2. Appendices
  - a) Brainstorming notes
  - b) Alaska Needs Assessment
  - c) All presentations listed/summaries

The group asked Lee Robison to do an outline of the report incorporating these recommendations. It is in the Action Plan list.

### **Summary/Validation of what the group has done regarding the integrated system**

The Paring was discussed in regard to the Prioritization of the criteria. Everyone thought the ranking would come out different however due to this group representing diverse interest it made the criteria ranking numbers very close together. This was discussed and the following new weights were approved by consensus. These will be used for Jose Cuzme to run several sample scenarios to see how these apply to different types of facilities.

#### **Criteria**

#### **Proposed Score:**

1. Facility Deficiency Scores

55

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2. Isolation	10
3. Documented Barriers	10
4. Health Indicators	15
5. Innovation	5
6. Type of Facility	5
Defining Thresholds for Types of Facilities	
a) Hospital	1
b) Medium size Health Center	5
c) Clinic	10

**Assignments for Next Steps**

<b><u>Action</u></b>	<b><u>By Whom</u></b>	<b><u>By When</u></b>
1. Run priority system/sample using I/T/U with the scoring that was developed	Jose Cuzme	three weeks
2. Contractor to develop utilization rate/develop formulas for threshold-below 1100	Jose Cuzme	Ongoing
3. Outline of final report	Lee Robinson	three weeks
4. Documents shared with the Area Health Boards, OEH Area Staff and Area Planners,	Workgroup I.H.S Hqtrs staff	immediately immediately
5. ACG needs to be explored as a methodology to develop health status.	Jose. Lee	Ongoing
6. Minutes	KAI	three weeks
7. Questions that needed to be answered		
a) Are all encounters including CHS in RPMS system?	I.H.S. Hqtrs	four weeks

**Meeting adjourned.**

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

MEETING HANDOUTS ARE AVAILABLE. IF YOU WISH TO HAVE THESE HANDOUTS, PLEASE CONTACT LEE ROBISON

Email: [Lee.robison@mail.ihs.gov](mailto:Lee.robison@mail.ihs.gov)

Address: Needs Assessment Handbook

% Lee Robison

IHS/OEHE

12300 Twinbrook Parkway, Suite 600A

Rockville, MD 20852

# **SACRAMENTO MEETING**

**JANUARY 24, 25, 2002**

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

**Indian Health Service Facilities Needs Assessment and Prioritization  
Criteria**

**WORK GROUP  
January 24, 25, 2002  
The Red Lion Hotel  
1401 Arden Way  
Sacramento, California  
(916) 922-8041**

**A G E N D A**

Thursday, January 24<sup>th</sup>

- |                 |   |
|-----------------|---|
| 8:00 – 8:15     | Refreshments  |
| 8:15 – 8:30     | Opening Prayer, Welcome and Introductions   |
| 8:30 – 8:45     | Review of Tulsa Meeting Minutes   |
| 8:45 – 9:30     | Exercise to Assess the Practical Impact of Workgroup<br>Recommendations – Lee Robison   |
| 9:30 – 10:00    | Discussion  |
| 10:00 – 10:30   | Break   |
| 10:30 – 11:30   | Identification of Any Weaknesses in New System We Propose   |
|                 | <ul style="list-style-type: none"><li>• <i>How should the prioritization process address projects funded primarily by tribes?</i></li><li>• <i>How should anomalies such as extremely remote locations be addressed in the prioritization process?</i></li><li>• <i>How should projects that involve no or minimal operational cost increases be incorporated in the prioritization process?</i></li><li>• <i>How should alternative financing and modular construction options be addressed in the prioritization process?</i></li><li>• <i>What can be done to make the current system for construction of facilities a more flexible and responsive program?</i></li></ul> |
| 11:30 – 12 Noon | Discussion and Changes as Needed  |

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

12 Noon	Lunch
1:30 – 2:30	Review of DRAFT Report to FAAB
2:30 – 3:00	Discussion
3:00 – 3:30	Break
3:30 – 4:30	Agreement on Revisions to Recommendations and/or Report
4:30	Recess

**Friday, January 25<sup>th</sup>**

8:00 – 8:15	Refreshments
8:15 – 9:00	Review Changes to Final Report Document – Jo Ann Kauffman
9:00 – 10:00	Discussion
10:00 – 10:30	Break
10:30 – 12 Noon	Development of Presentation of Recommendations to FAAB <ul style="list-style-type: none"><li>- Who will make the presentation?</li><li>- When will presentation be made?</li><li>- What support/materials/graphics will be needed?</li><li>- How do Workgroup Members want to be represented?</li></ul>
12 Noon	Lunch
1:30 – 2:30	Final Workgroup Directives to IHS <ul style="list-style-type: none"><li>- Dissemination of Report</li><li>- Supporting Materials</li></ul>
2:30 – 3:00	Concluding Discussion of Workgroup
3:00	Adjournment of Workgroup

## **Indian Health Service Facilities Assessment and Criteria Workgroup**

### **Meeting Minutes For January 24, 25, 2002 Meeting in Sacramento, California**

#### **Workgroup Participants Present::**

Sara DeCoteau, Sisseton-Wahpeton Sioux Tribe  
Chairman Arlan Melendez, Reno-Sparks Indian Colony  
Rod Smith, Northwest Portland Area Indian Health Board  
Robin Carufel, Lac du Flambeau Chippewa  
Gary Markussen, California Area Advisory Member  
Jerome Simone, United Indian Health Services  
Rick Boyce, Alaska Native Tribal Health Consortium  
John Guinn, YKHC  
Helen Bonnaha, Navajo Nation  
Camelita Skeeter, Indian Health Council Resource Center  
Adrian Stevens, Seneca Nation  
Ervin Chavez, Navajo Nation and FAAB

#### **Others Present:**

Jo Ann Kauffman, Facilitator, Kauffman and Associates, Inc.  
Lee Robison, IHS/OCHE  
Jose Cuzme, IHS/DFPC  
Allison Binney, (Guest) Hobbs, Straus, Dean & Walker

Opening Prayer was provided by Helen Bonnaha from Navajo Nation.

- Minutes:** The minutes from the Tulsa meeting held October 25, 26, 2001 were reviewed for corrections. There were several minor corrections, including corrected spellings and correcting the name for California Rural Indian Health Board. The section “assignments and next steps” was amended to show that activity #2 “Contractor to develop utilization rate and develop formulas for thresholds below 1100” should be shown as “ongoing” with no deadline as this can be a lengthy process. Also in this section, action item #5 “ACG needs to be explored as a methodology to develop health status” should be shown as an “ongoing” item with not time restriction. KAI will reflect these changes in the final version of the minutes.
- Practical Impact of Workgroup Recommendations:** Lee Robison provided an overview of his analysis of the practical impact of the recommendations proposed by the Workgroup (see attached power point slides). The Workgroup report will be forwarded to the FAAB. There will

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

also be a Federal Review Process and a Tribal Review and Input process following this report. So far, our recommendations are similar to the existing system in that they rely upon the Facilities Deficiency System, which utilizes population and workload, existing space compared to needed space adjusted for facility age and facility condition. Our proposal to factor “isolation” is also in the existing system. Our proposals differ from the current system in that it is dependent upon a national “Needs Assessment”, and considers new factors such as Documented Barriers, Health Status, Innovation and Type of Facility. Our recommendation may be used “as is” in its entirety; modified; or some used some set-aside. Currently some of the projects in the existing list are not moving forward for a variety of reasons. New projects need to be identified for the priority list utilizing either the current system or some variation of our proposal.

3. **Strengths and Weaknesses in Our Recommendations:** The Workgroup discussed the strengths and weaknesses of each of the recommendations developed so far. There were some changes made to the proposed recommendations based upon this discussion. The final recommendations that will go into our Final Report are described below.
4. **Sample Application of Proposed Priority Criteria:** Jose Cuzme presented a sample of how the proposed priority criteria could be implemented using the “draft priority system”. Each of the draft criteria were plotted on a graph to show how values could be assigned to rate various proposals. For example a graph was presented that showed a value of 0 to 100 % of needed space available for a facility. Based upon where a facility falls in relation to their needed space and available space they would be assigned a factor of 0.00 to 1.00. Similar graphs were presented to show ranking for “Isolation”, based upon miles to a hospital. Another graph showed how values could be assigned based upon a community’s infant mortality rates as a ratio of the national rate. More difficult to measure and rate is the question of “Access Barriers other than Distance”. While this criterion is meant to value barriers such as language/culture, local discrimination, economic barriers, etc., it is difficult to apply. Two graphs were presented. One measured percent of the user population with access to public transportation. The Workgroup did not think this was a fair or accurate measurement of access barriers, particularly in urban areas, where public transportation is available but access to health care is still difficult. Another graph was presented that showed annual household income as a percent of U.S. average income. There were some concerns voiced about whether this should be applied given opposition to “means testing” for IHS services. More consultation will be needed to better apply the Access Barriers criterion. Models were also presented describing ways to measure “Innovation/Collaboration” and “Type of Facility” based upon floor space.

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

5. **Presentation by CRIHB:** The California Rural Indian Health Board (CRIHB) made a brief presentation, welcoming the Workgroup to California and providing an overview of health issues in California. CRIHB then hosted a reception for the participants.
6. **Presentation to the FAAB:** The Workgroup agreed that a presentation to the FAAB should occur prior to their June, 2002 meeting. FAAB Chairman Ervin Chavez will make the arrangements for the presentation. He will select several members of the Workgroup to assist him and John Guinn made the presentation. The Workgroup recommended that Rick Boyce represent the Workgroup when the presentation is made.
7. **Revisions to Workgroup Recommendations:** Each of the recommendations proposed by the Workgroup was reviewed one more time. Changes were made and the final recommendations are as follows:

## **RECOMMENDATIONS**

### ***A. Needs Assessment Recommendations***

Much of the recommendations proposed by the Workgroup regarding Needs Assessments are based upon the assumption that the HSP system can be easily applied in a fair, consistent manner across all 12 Areas.

1. **Health System Planning:** We recommend that the IHS in consultation with the I/T/U's implement the "Health System Planning" (HSP) software/model be applied locally to determine the services and facilities required in individual service areas nation-wide. Based upon these community-specific or service area specific HSP analyses, a community specific Master Plan will be generated to quantify the costs associated with the construction of expanded, replaced or new facilities.
2. **Area Master Plans:** We recommend that the results of the community-specific HSP services and facilities analyses be integrated into a regional Area-wide Master Plan for each of the 12 IHS Areas, in consultation with I/T/U's, which will describe the services and facilities for the area, the required expanded, replacement or new construction for needed facilities and estimated costs associated with those projects.
3. **HSP Adaptability:** We recommend the IHS invest in making the necessary modifications to the current HSP technology, so that communities of not less than 100 users can be included in the updated HSP analysis.
4. **Space Deficiency for Core Services:** We recommend that calculations for space deficiency which results from application of the HSP will be based only upon those "core health services" currently within the template formula of the

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

HSP. We caution the expansion of these templates until there is consultation and agreement regarding space requirements for off-template services.

- 5. Off-Template Services and Future Planning:** We recommend that the IHS invest in a long term plan to develop formula for templates for alternative services not currently described in the HSP to be applied in the future. These alternative services could include, but not be limited to, wellness centers, long term care facilities, traditional medicine, alcohol and substance abuse treatment, preventive services, etc.
- 6. Unit Price Budgeting:** In accordance with acceptable IHS Standards, we recommend that regionally appropriate unit price budget calculations be utilized within each of the Local and Area Master Plans to calculate preliminary estimated costs associated with construction projects.
- 7. Repair vs. Replacement:** We recommend that industry standards be followed for determining repair or replacement options, such that if repair estimates exceed 75% of replacement estimates, projects may be recommended for replacement.
- 8. Non-IHS Funding:** We recommend that each Area Master Plan include a thorough description of the space and dollars in new or replacement construction of tribal and urban health facilities constructed with non-IHS dollars, from 1996 to present, which are included in the Area Master Plan.

### ***B. Rating Criteria Recommendations***

We recommend that the IHS NOT apply the current, existing HFCPS to add facilities to the priority lists. Rather, we recommend a new system be implemented for any future priority ranking based upon the specific proposals and recommendations contained in this report.

The Workgroup decided that those competing facilities should be ranked according to the following two categories: (1) Urban Indian facilities will be ranked with other Urban Indian facilities when requesting consideration for Title V funding; and (2) Tribal and I.H.S. facilities will be ranked against each other when requesting consideration for funding under the construction line-item of the I.H.S. budget.

- 1. Master Plan Required:** To be considered for the priority list, a project must be included in its respective Area Master Plan.
- 2. Relative Criterion Weights:** The Workgroup recommends that the following criteria be used with the corresponding relative weights shown:

<b><u>Criteria</u></b>	<b><u>Proposed Weighting:</u></b>
a. Facility Deficiency Scores	35
b. Isolation	10
c. Documented Barriers	10

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

d. Health Indicators	15
e. Innovation	15
f. Type of Facility	15

### **3. Justification and Explanation of Proposed Criteria:**

- a. Facility Deficiency Scores:** These scores weigh the greatest in the proposed criteria. The score reflects the gap between existing space and required space as determined through the HSP analysis. Factors such as facility age, condition of facility, and user population are included in this analysis.
- b. Isolation:** This criterion refers to the physical distance of the population to the nearest health center or hospital. To receive full weight for this criterion a community would need to be 60 miles or more from the nearest hospital and 30 miles to the nearest outpatient facility, or removed from that facility by air travel or water. The closer the alternative facilities, the less weight assigned.
- c. Documented Barriers:** This criterion could be calculated in a number of ways, and is included to cover “access barriers other than geographic distance”, such as economic barriers, cultural barriers, transportation barriers, racial discrimination other socio-economic factors. Developing objective measures that can be documented and consistently applied will be a challenge.
- d. Health Status Indicators:** Health status indicators represent a new and important addition to facility construction ranking criteria. This criterion can also be calculated in a number of ways. For purposes of discussion, we have presented two options, one looking at infant mortality rates as a ratio to national U.S. rates, and “Years of Productive Lives Lost” (YPLL) as a ration to U.S. rates. There may be other, more appropriate measures, such as those under development at Johns Hopkins University which will incorporate a range of both morbidity and mortality data.
- e. Innovation:** Significant weight is assigned to this “new” criterion proposed by the Workgroup. Additional work is needed to define the types of innovations, which might qualify for added weight. For discussion purposes, we have provided examples of innovative steps, which could provide incremental points in this area. This could include investments of non-IHS dollars in the project, collaboration with other tribes or consortia, or regional partnerships.
- f. Type of Facility:** These factors will be consistent with the standards for services and facilities reflected in the HSP. The Workgroup wanted to provide a mechanism to prioritize smaller outpatient facilities over inpatient facilities and support community-based prevention and primary care. This criterion would be applied based upon a grid that assigned values inversely to projects based upon size. The larger the project the lower the value. The smaller the project the greater the value.

Defining Thresholds and Values for Facility Types

- i) Medical Center or regional inpatient facilities

## ***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

- ii) Small Hospital and other local inpatient facilities
- iii) Primary Care Health Center and other comprehensive outpatient settings;
- iv) Health Station and other solo practitioner stations

### ***C. Integrated System Recommendations***

These recommendations are based upon an assumption that Congress will provide recurring construction appropriations, which can be allocated consistent with the proposed recommendations below.

- 1. Universal Priority List:** The Workgroup recommends that priority ranking be conducted for all of the many construction programs proposed in each of the 12 Area Master Plans of the IHS, not just the 10 top outpatient and 10 top inpatient facilities. From this ranking a universal national priority list will be produced that includes all projects in the Area Master Plans, including inpatient, outpatient, dental, joint venture, small ambulatory clinics, staff quarters, regional youth treatment centers and other proposals in the Master Plan. New services that are currently outside the existing HSP template, such as long term care, wellness centers, etc., will be added to this priority list as developed and accepted under an amended national HSP format.
- 2. National Priority List for Congressional Consideration:** From the Universal List, all projects which have implications for recurring costs (staffing, operations) will be compiled in a National Priority List for consideration for Congressional appropriations. This may include inpatient facilities, outpatient facilities, staff quarters, joint venture projects, etc.
- 3. Area Priority List:** All construction projects that do not involve new or expanded staffing or increased recurring commitments from the IHS, will be deferred to the Area Priority List in each of the 12 IHS Areas. These may include regional youth treatment centers, dental clinics, small ambulatory care clinics, or other innovative or alternatively funded projects. Area ranking of these projects will be conducted based upon the proposed criteria.
- 4. Area Percentage Allocation:** We recommend that a percentage of annual construction appropriations be allocated to each of the 12 Areas according to a need-based formula. Each Area will determine for themselves how best to allocate these Area construction dollars according to the Area Master Plan and Area Priority Lists, including but not limited to, construction costs, debt relief, loan guarantees and other innovative construction strategies.
- 5. Authorizing Statute Amendments:** We recommend that IHS seek Congressional amendments to authorizing statutes to eliminate threshold restrictions on categorically authorized and funded facility construction programs, such as small ambulatory clinic restrictions to communities with 2,000 users or more, to be consistent with existing HSP formula and proposed integration recommendations.

## **D. DAVIS/BACON WAIVERS**

The Workgroup is recommending that Congress provide a waiver of the Davis Bacon Act for all construction funded through the IHS appropriations. This waiver can be achieved through either authorizing statute or through annual stipulations on the Interior Appropriation Acts.

It was agreed that KAI will revise the Final Report and provide more justification narrative for each of the proposed recommendations. KAI will also add an Executive Summary in the Final Report. KAI will get the revised Final Report to Lee at IHS within two weeks. This document will be copied and made available to the Workgroup and the FAAB. It is assumed that a lengthier and more formal consultation process will be initiated by the FAAB and IHS based upon these recommendations.

This completed the work of the Facilities Workgroup. Closing Prayer. Adjourn.

***NEEDS ASSESSMENT AND PRIORITY CRITERIA RECOMMENDATIONS***

MEETING HANDOUTS ARE AVAILABLE. IF YOU WISH TO HAVE THESE HANDOUTS, PLEASE CONTACT LEE ROBISON

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